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AUTHOR Tymchuk, Alexander
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ABSTRACT

The final report examines the 1977-78 accomplishments of the outreach program at the Dubnoff Center, which served 44 handicapped infants and preschool children. The program is explained to remediate children's developmental delays while preventing additional problems and to train parents to be effective advocates for their children. Goals and achievements are addressed regarding the children (referral, evaluation, program development, intervention, and program effects on IQ and MA). Sample parent questionnaires on child development, handicapped conditions, attitudes, resources, and self concept are included. A section on the program's involvement with teachers includes questionnaires on normal child development, social learning, and attitudes. Nearly one-half of the document is composed of appendixes, including information on the project's videotape coding system and a detailed analysis of the individual educational program process by A. Tymchuk, A. Dahlman, and I. Mooring. (CL)

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Evaluation of Dubnoff Center's Outreach Program 1977-1978

Final Report

31 August, 1978

Alexander Tymchuk, Ph.D.
University of California, Los Angeles

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I Program Overview

History of the Dubnoff Outreach Program

This report describes the accomplishments for the year 1977-1978 and is the second year after a major change in the program. Where before 1976-1977, the Outreach program was primarily service-oriented, in 1976, the Office of Education in Washington made a commitment to the systematic evaluation of the efficacy of the various programs. Programs were to demonstrate conclusively that the changes in children were attributable to the program efforts; that the program was clearly described and could be replicated; that it had parental support; that there was an effect upon other agencies and that training in areas where there was a manpower shortage would be addressed.

Consequently, the Dubnoff program ennumerated and classified its goals and objectives, the techniques to fulfill these goals, the process whereby these goals would be achieved and a methodology that would evaluate this achievement. These changes were met with resistance by some Dubnoff Outreach staff and consequently, the leadership of the Dubnoff Outreach changed. The difficulties in this changing coupled with the need for clear goals, techniques, processes and evaluation, made the first year, 1976-1977, necessarily short. Consequently, the results of the evaluation on the children were good, but not great; however, by other measures, the program was a great success. The new staff was hired and trained; new community relationships were established and needs assessment done; goals were established along with techniques, timetables for implementation and evaluation methods selected and used: workshops and courses were given; parents seen; children served; and results disseminated.

A Needs Assessment

The experience of the first year, analysis of the results of that year, as well as a needs assessment of the Outreach catchment area, provided Dubnoff with some of the goals for 1977-1978.

1 Previous Experience

In terms of the types of services provided the previous experience indicated that similar services should be provided as well as the manner in which they should be provided.

2 Analysis of Results

The results indicated that perhaps the standardized instruments

may not be sensitive to the intervention. The Vineland Social Maturity Scale (VSMS) had been selected because it covered a number of areas; however, the norms on which it was based were old and limited. The Allpern-Boll (A-B) then was selected. The Peabody Picture Vocabulary Test (PPVT) was kept. In addition a behavior observation format was developed.

3 Needs Assessment

A questionaire was circulated to the staffs of the participating agencies to determine their needs. The needs in rank order from most often requested to least often requested were handling behavior problem children, integrating the handicapped, assessing childhood needs, parent counselling, curriculum methods, behavior modification, information on handicaps, normal child development, legislation and resources.

II Program Objectives

The program was based upon the assumption that children who were at risk in their development could be helped best when worked with at a very early age. Such interventions, in order to be maximally effective, must consider the child's total environment including the school, family and community.

A. With the Children

The general goals for the children were: 1) remediation of developmental delays or deficits and, 2) the prevention of possible problems by providing ongoing intervention. The specific areas for remediation were: sensorimotor behavior, self-help skills, social behavior, academic behavior and communication skills.

B. With the Parents

Since parents are the ones who spend the most time with their children, parents can be trained to be effective advocates for their children. To be effective as advocates, parents need to be informed of their rights as well as those of their children. They need to be aware of the resources available to them, including schools and special services, parental and professional organizations and financial help. Parents need to have realistic expectations of and attitudes toward their child, toward themselves and toward professionals so that there may be optimal growth of their child. And parents need accurate knowledge about their child's disability as well as of his/her abilities.

C. With Teachers and Staff

With the advent of public law #94-142, more severely handicapped children are being seen in all schools. Teachers need information about the particular handicaps as well as how to remediate them. They need information on how to work with parents as well.

TABLE I

Children, Parents, and Teachers Served

		Number of Children	Number of hours of Intervention for 10 months	Number of Parents	Number of hours of Counselling	Number of Teachers Consulted with	Number of hour of Consultatio
nsite	Infants	3	378	4	84	.5	21
	Toddlers	10	1680	15	315	.5	21
	Preschoolers	31	19530	20	200	2.0	10
	TOTAL	44	21588	39	599		
ffsite	San Fernando Valley Child Care Consortorium & Latin American Civic Association	31	124	28	188	11	110
	Unaffiliated Day Care/ Preschool Children's Centers	61	244	37	52	30	60
	TOTAL	92	368	65	240	41	170

TABLE 2

Goals with Children

Goals	How Assessed		Intervention	
	Onsite	Offsite	Onsite	Offsite
To maintain or improve abilities in: Sensorimotor behavior Self-help skills Social behavior Academic behavior Communication skills	Standardized Tests 1. Peabody Picture Vocabulary Test (PPVT) 2. Allpern-Boll 3. Bayley	not used	Individualized assessment and IEP development; group and individual intervention; teacher training and supervision	
	Non-standardized Tests 1. Behavioral observation 2. Videotaping 3. Audiotaping	none none		

TABLE 2

Goals with Children

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	Non-standardized Tests 1. Behavioral observation 2. Videotaping 3. Audiotaping	none none		

III The Program

A For the Children

There were two parts to the program including the Onsite and the Offsite portions. Where the Onsite program was funded by the State Department of Education funds, Regional Center fees and Dubnoff contribution, the Offsite program was funded by the Bureau for the Education of the Handicapped (BEH) as well as by Dubnoff contributions. Both programs followed similar goals and methods.

The Onsite and Offsite programs are summarized in Table 1 showing the number of children, parents and teachers served as well as the number of hours spent in those efforts. Figure 1 depicts the process and content of both segments.

1 Referral and/or Screening

For the Onsite program, children between 1 month and 60 months are referred by community groups and by individuals to the project director. These children and their parent(s) and/or guardians/advocates are seen by an initial screening commitee to determine eligibility and to gather initial data. Funding is sought for those who are eligible and for those who do not have funding most are given scholarships. Those who are of particular interest are parents who are themselves mentally retarded. This group represents an underserved population.

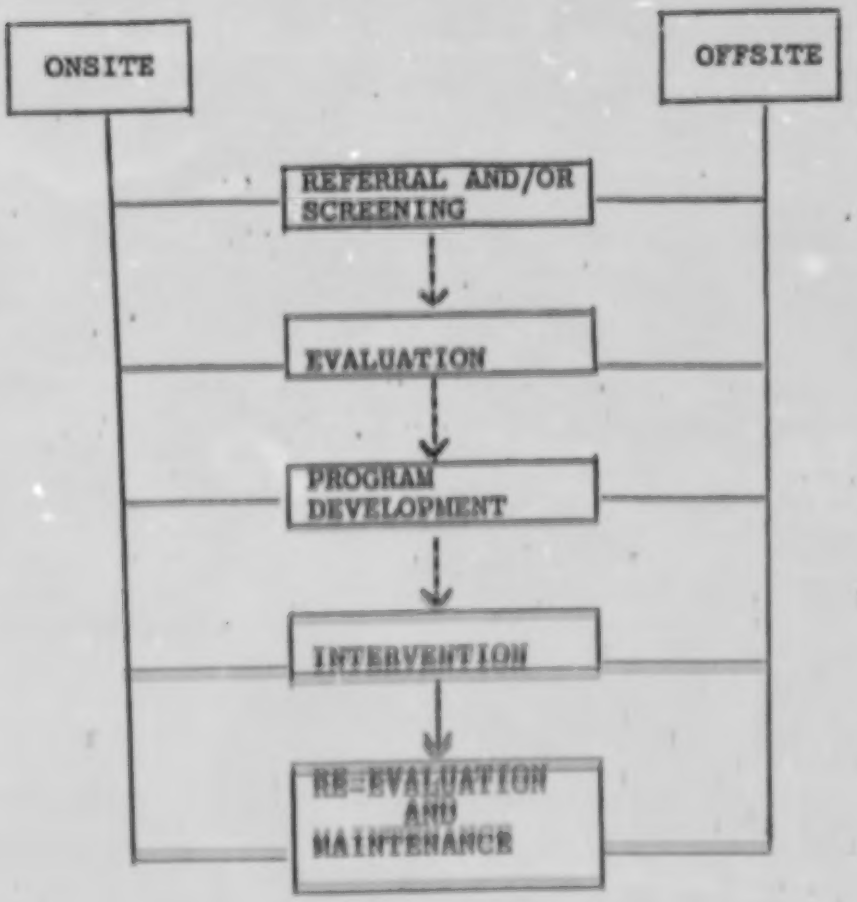
For the Offsite program, teachers and/or social workers at the various Head Start sites make referrals to the Outreach consultants. All referrals are accepted and are provided consultation on a first-come, first-served basis.

2 Evaluation

For the Onsite program, all children are seen at Dubnoff and at home. A summary of the evaluation procedure is in Table 2. All children who were of age were given the PPVT-Form B individually. For the very young children, the Bayley was given and all children were given the Allpern-Boll which is based upon parental report. All infants were videotaped by themselves and in a group. These tapes were for observation, establishing reliability and to demonstrate efficacy visually. All parents consented to the taping, but several indicated that the tapes were not to be shown outside of the program. Several children who had communication disorders were audiotaped periodically to provide a demonstration of efficacy.

FIGURE I

FLOWCHART SUMMARIZING DUBNOFF'S OUTREACH PROGRAM



For the Offsite program, all teachers provide initial data on the child and an observation is done. For the purpose of demonstration efficacy, all children on the initial referral list were given the PPVT and the Alpern-Boll. However, there is an ethical problem in not providing an intervention where one is needed and yet there is a need to provide a demonstration of efficacy. To overcome this difficulty, two procedures were implemented. First, a multiple baseline procedure was utilized which is the first time that this procedure has been used in evaluating an Outreach program. Basically, observation is made on two dissimilar behaviors such as motor skills and language and for a time, intervention is made on one of those behaviors and not the other. There should be improvement on that variable and not the latter; once such improvement is shown then intervention can begin on the second variable. This procedure is justified since the teachers cannot do all interventions at once with the same duration and intensity and as such, the multiple baseline procedure approximates the natural situation.

Second, since not all children can be given consultation simultaneously, some will be seen later than others. All, however, must be evaluated to determine strengths and weaknesses. With this in mind, all children were evaluated when they were first referred and then they were re-evaluated either when they left the program, when they received consultation if such consultation was given after at least 8 weeks after the first evaluation or at the end of the year; thus, there were children who formed two natural groups; an intervention group and a waiting list group. Those still on the waiting list at the end of the year would receive first priority the following year provided that funding was continued.

3 Program Development

All children who were served had an Individual Education Plan (IEP) developed according to the format and process developed by Tymchuk, Dahlman and Mooring (1977) (See Appendix). A sample IEP is in Table 3.

The content for the IEP is based upon curriculum practices developed at Dubnoff with the recognition that children learn better under conditions that recognize and adhere to individual style and reinforcement preferences. The social learning principles as enumerated by Tymchuk (1974) provided the techniques whereby the content was taught.

The content derived from formal child development researchers including Hunt who addresses the issues of intrinsic reinforcement and the reinforcing value of information processing and incongruity and from Reese and Lipsett who have shown that there is an orderly progression to development and have identified some of these progressions in cognition. The content also derived from less formal child development research including the Portage curriculum package and the Ypsilanti package.

Dubnoff recognized the limitations of current curriculum packages in that none covers the entire child's development from infancy through young adulthood and none covers the variety of behaviors. Dubnoff is developing its own curriculum that recognizes that social learning principles tell us how to teach the what to teach comes from the sources already referred to.

4 Intervention

The actual intervention for Onsite children included:

Infants	(0 - 18 months)	twice weekly for 1½ hours
Toddlers	(18 - 36 months)	twice weekly for 2 hours
Pre-school	(36 - 60 months)	five days per week for 3 hours

For the Offsite children, the children were seen on consultation at:

Headstart
Preschool
Children's Centers
Family Day Care Centers

Table 1 depicts the number of hours of intervention.

Child's Name: Alan

Curriculum Area: Social Behavior

(I.P.O)

Date Started:

Date Completed:

Teacher:

Objective	Teaching Strategies	Materials
I.P.O. I. Will behave properly in school A. Will follow commands 1. look at me 2. come here 3. give me_____ 4. sit down 5. pick up_____ B. Will sit at desk for progressively longer lengths of time C. Will be able to perform simple perceptual tasks. 1. string beads from model 2. put 5 piece puzzle together 3. sort red & yellow blocks by color 4. match colored pieces of paper by shape (square,circle, triangle) II. Will behave at home and in school	T (teacher) alone with C (child) at first. T will give C command, "look at me". If C does, T will praise him and give piece of chip. If C does not, T will repeat command. If C tantrums, T will say "no!, stop yelling" and turn away until he has ceased for 30 seconds. T will praise him for being quiet and repeat command. Commands and tasks varied as process repeated. If C succeeds, mother will come in as reinforcer and then to work on tasks. Generalization to home and school.	Three dimensional blocks, red and yellow; potatoe chips; colored paper; wooden puzzles of elephant, clown and house. Criteria: Time at task will increase to 5 minutes witl crying. Will respond to commands 4 of 5 tin Baseline: Tantrumed incessantly, unable to do any tas

Form E/7c

Table 4
Types and Frequencies of Major Presenting Problems Among Children Served

	Onsite	Offsite
Developmental Delay	26	28
Aggression	1	22
Withdrawn	4	5
Speech Difficulty	3	18
Hearing Difficulty	3	2
Physical Disability	4	2
Emotional Disturbance	2	5
Abuse	1	4
Other	0	6
Total	44	92

Table 5

Number of Children, Their Sex and Average Ages (in months) for the Onsite, Offsite and Contrast Groups

	Males	Females	Age
Onsite	16	9	47.4
Offsite	8	7	54.2
Contrast	6	7	53.2

5 Results With Children

The results for the children are summarized in Tables 1 through 9. Table 1 shows that 44 children were served Onsite including 3 infants, 10 toddlers and 31 preschoolers for a total of 21,588 intervention hours. In addition 39 parents were seen and given a total of 599 hours of counselling. Three teachers and their assistants were given 52 hours of consultations largely related to individual evaluations and programming.

For the Offsite program, 31 children were seen in Head Start and 61 in Day Care/Preschool/Childrens Centers for a total of 368 hours of consultation. Sixty-five parents were seen for 240 hours of counselling and 41 teachers were given 170 hours of consultation.

Table 4 shows the breakdown of type and frequency of major presenting problems for both Onsite and Offsite programs. The majority were seen as developmentally delayed for both groups and aggression and speech difficulties being the next most frequent problem for the Offsite group.

Table 5 shows descriptive demographic data for those children for whom complete pre-and post-intervention data were available.

The data reported here are for the Onsite preschoolers only since they are comparable to the Offsite consultation and non-consultation groups.

The questions to be answered were:

Did the Onsite and Offsite intervention and consultation groups improve significantly as a result of the intervention?

Did the Onsite and Offsite groups improve significantly more than did the contrast group?

In order to answer these questions two-way analyses of variance (ANOVA) were done on each variable (PPVT - IQ, PPVT - MA, Allpern-Boll IQ). The factors were Intervention (Pre and Post) and Groups (Onsite, Offsite, Contrast) so that the ANOVA was a 2 X 3 with repeated measures.

Table 6 contains pre and post means, standard deviations and ranges for PPVT - IQ, and PPVT -MA, for the three groups. Where the Onsite group had a mean IQ of 87.4 before intervention,

there was a mean of 96.86 afterwards. The Offsite group improved from 92.3 to 100.8 and the Contrast group only went from 97.1 to 99.2. The three groups did not differ significantly before or after intervention. Both groups (Onsite and Offsite) improved significantly whereas the Contrast group did not, but either group did not improve significantly more than the Contrast group.

Another way to measure efficacy, however, is to make comparisons between the various groups and the normal population as represented by the norms upon which the test is based. The PPVT can be used for this type of analysis. Table 8 contains the mean raw scores and percentiles for the three groups both before and after service. The data show that the Onsite groups increased 9 percentile points, and the Offsite Intervention group 27 while the Contrast groups actually decreased 10 points in comparison to the norms. This finding suggests that the consultation does have a significant impact over that of just being in Head Start.

What these data also shows is, since those in the Contrast group were in Head Start as well, that Head Start works too. There is another factor to be considered and that is those who are Onsite have lower IQ's than those who are Offsite, in addition the contrast group has a higher mean IQ than does the other Offsite group. This result suggests that first, children with greater handicaps are referred to an intervention program such as Dubnoff's where there is great experience in working with handicapped children. These results also suggest that the children to be referred first by Head Start are probably the ones needing more help. Taken together, these results suggest that the gains shown by the Onsite and Offsite intervention groups have even greater significance since these children are the most difficult to work with.

Table 7 contains average changes.

Table 6

Pre and Post Means, Standard Deviations and Ranges for Peabody Picture Vocabulary Test IQs and Mental Ages (MA) for the Onsite and Offsite Service and Offsite Contrast Groups

	Pre		Post	
	IQ	MA (months)	IQ	MA
Onsite	87.4 15.1 62-120	44.2 12.5 25-70	96.86 16.5 71-125	56.3 12.7 33-78
Offsite	92.3 13.8 71-116	51.6 13.3 33-78	100.8 6.9 88-116	63.8 9.9 45-78
Contrast	97.1 16.2 69-125	51.9 13.1 34-78	99.2 10.6 88-123	60.1 10.9 50.87

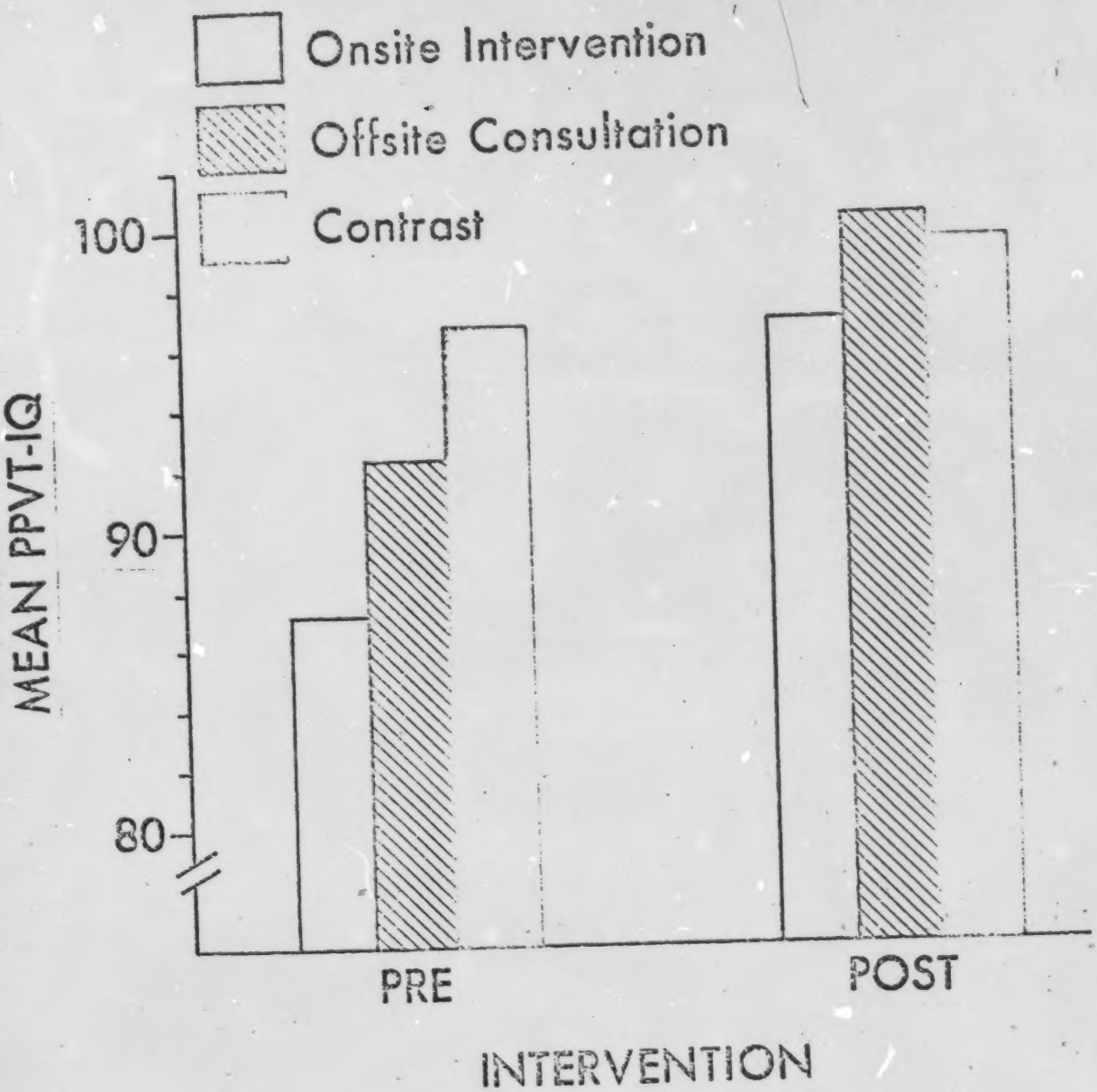


Figure 2

Pre and post Peabody IQ scores for three groups.

Table 7

Mean Changes in PPVT - IQ and MA for
the Onsite, Offsite and Contrast Groups

	IQ	MA
Onsite	9.4	12.1
Offsite	8.5	12.2
Contrast	2.1	8.2

TABLE 8

Percentile Changes for PPVT-IQ

	Pre			Post			
Group	Mean Age (mos)	Mean Raw Score	Percentile	Mean Age (mos)	Mean Raw Score	Percentile	Percent Chang
Onsite	47.4	35	26	55.0	43	35	+9
Offsite	54.2	41	24	62.2	50	51	+27
Contrast	53.2	43	35	61.1	45	25	-10

TABLE

	PRE						POST					
	Physical Age	Self Help Age	Social Age	Academic Age	Communi-cation Age	I.Q. Equiva-lent	Physical Age	Self Help Age	Social Age	Academic Age	Communi-cation Age	I.Q. Equiva-lent
NSITE	54.4	62.9	49.1	41.0	45.7	85.2	65.6	70.8	65.8	54.9	58.1	97.7
	17.1	15.5	17.4	8.3	9.7	17.8	14.1	14.1	13.9	9.6	8.8	19.2
	26-86	24-86	18-90	26-58	30-60	60-118	46-94	32-94	36-86	36-70	42-76	70-152
FFSITE	57.3	66.1	60.1	44.4	58.1	82.1	80.2	86.7	73.3	62.1	62.9	106.4
	12.4	11.7	7.8	5.3	9.4	9.2	11.2	9.4	6.9	6.9	4.6	11.5
	44-90	50-98	50-82	38-54	48-86	63-96	60-99	66-99	60-86	48-78	54-70	85-130
NTRAST	56.1	65.7	58.3	51.7	54.9	97.6	85.2	91.7	71.7	58.6	68.6	97.6
	9.6	7.3	8.1	4.7	7.3	9.9	8.6	9.1	8.6	5.3	5.1	7.2
	42-74	54-78	50-74	42-58	42-66	82-116	74-99	74-99	54-86	48-66	56-78	83-109

PRE AND POST MEANS, STANDARD DEVIATION AND RANGES FOR THE ALLPERN-BOLL IN MONTHS FOR THE ONSITE, OFFSITE AND CONTRAST GROUPS

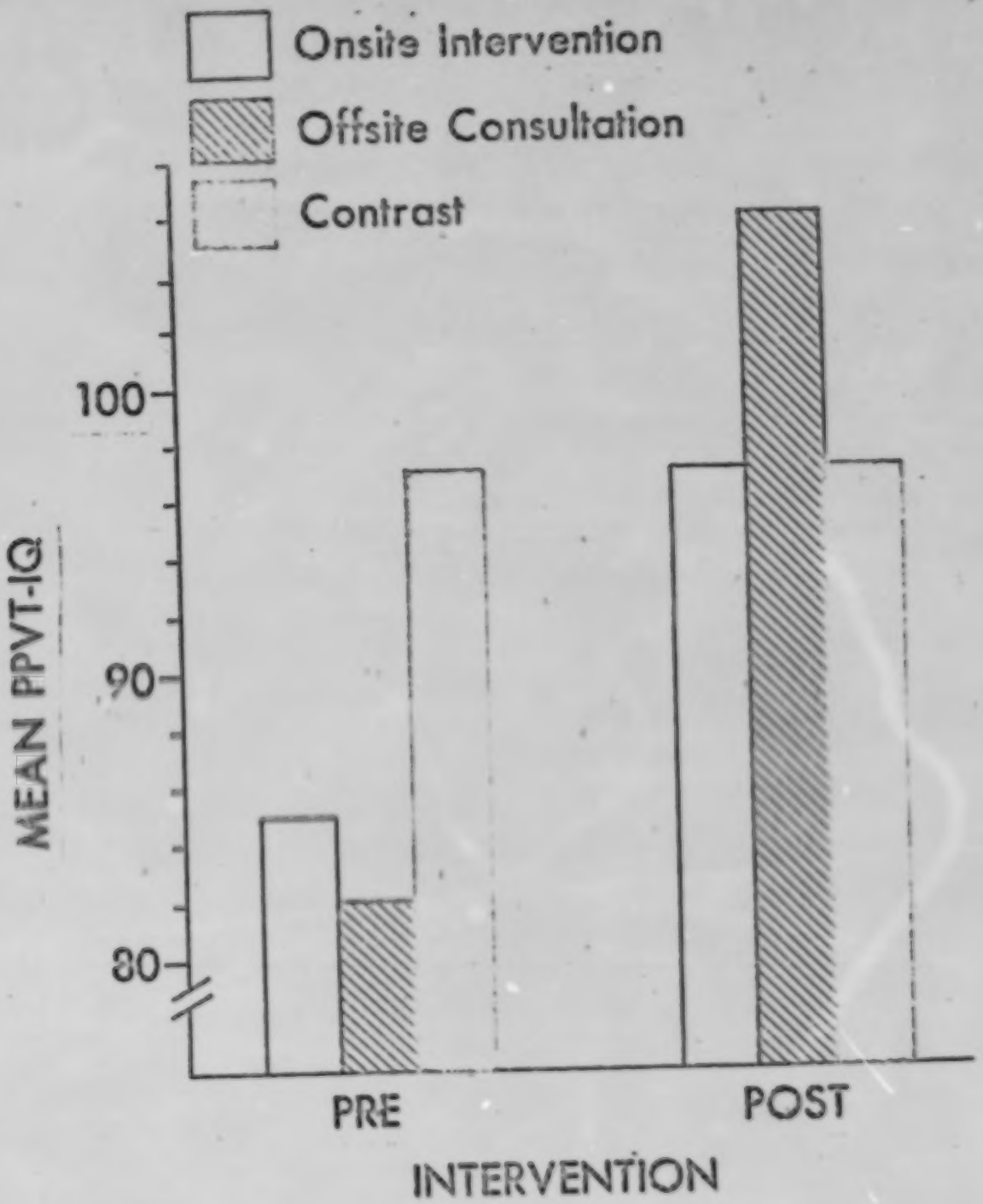


Figure 3
Pre and post Allpern-Boll IQ equivalent scores for three groups.

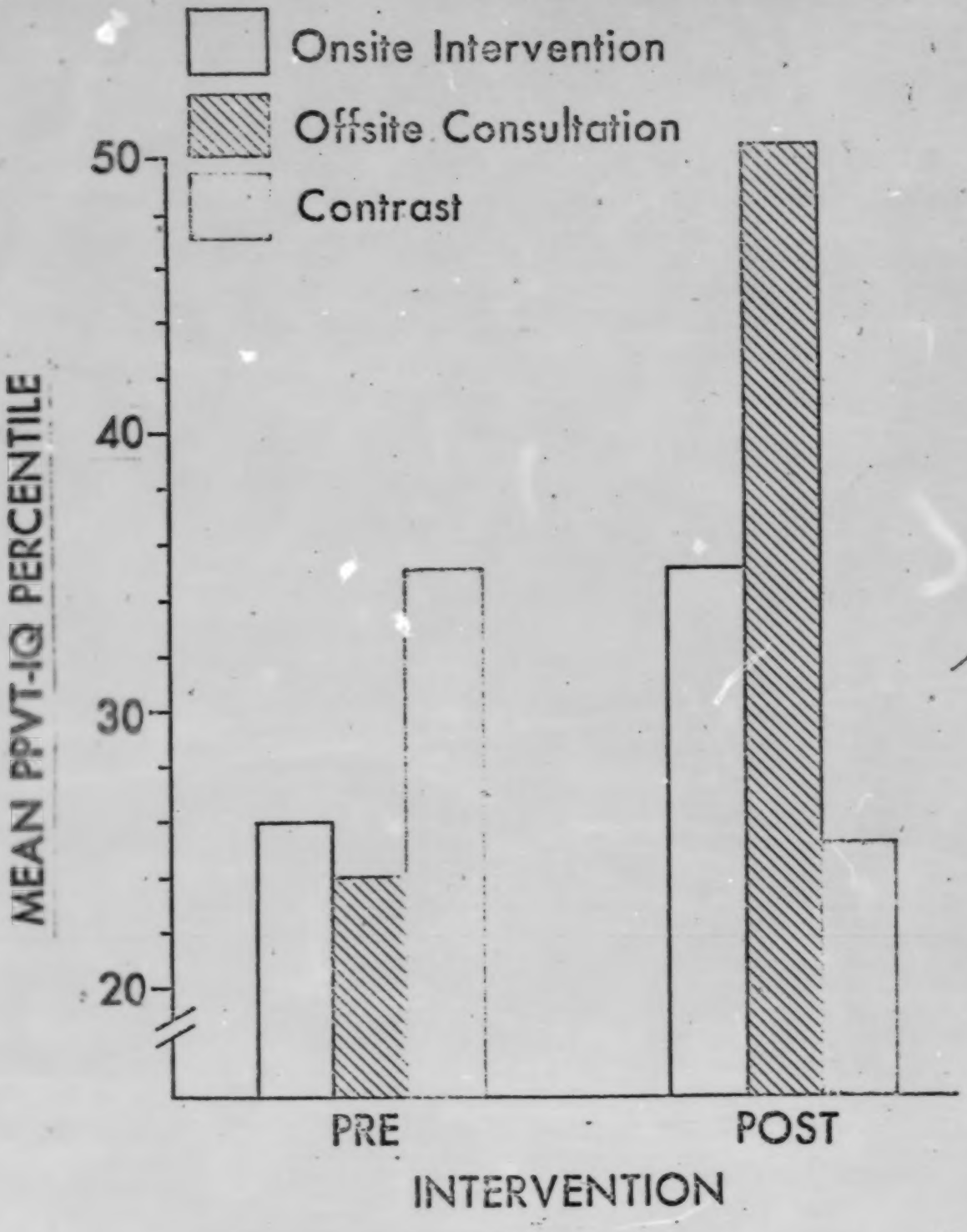


Figure 4

Pre and post PPVT-IQ percentile scores for the three groups.

Table 9 lists the means, standard deviations and ranges for pre- and post-intervention assessments for the three groups for the Alpern-Boll.

The Onsite group improved an average of 12.5 equivalent IQ points, the Offsite consultation group 24.4 points and the Offsite-Contrast group did not improve at all. These differences show that not only did the two intervention groups improve significantly from pre- to post-testing, but also that they did significantly better than did the contrast group ($F = 10.79$, $df = 2.45$, $p < .0001$).

Individual t-tests were done to determine where the differences were and for the respective comparisons, the t's = 5.23, df = 2/25, $p < .0001$ (Offsite versus Contrast) and $t = 2.23$, df = 8/29, $p < .03$ (Onsite versus Contrast).

Figures 2,3 and 4 depict the results graphically.

Table 10

Goals with Parents:
How Evaluated and Intervention Strategies

Goals	How Assessed	Intervention
I. To improve their caretaking abilities in the following areas: a. identification of child's needs b. establishing caretaking goals c. implementing caretaking	Pre-Post observation and videotaping where possible of parent working with child. Parent evaluation form. Attendance.	Parent Training
II. To develop realistic attitudes regarding their child	Pre-Post testing on Parental Attitude. Research Instrument (PARI). Also translated into Spanish.	Individual and group parent counseling. Parents receive parchment diploma for attending.
III. To increase their knowledge and use of resources in the following areas: a. financial b. legal c. medical d. educational	Pre-Post testing on questionnaires on resources and a review regarding utilization of resources. Also translated into Spanish by staff.	Group parent counseling.
IV. To increase their knowledge regarding: a. normal child development and how handicaps can change this development b. diagnostic entities	Pre-Post testing on questionnaire on child development and handicapping condition. Also translated into Spanish by staff.	Group parent counseling.

B Program for Parents

The program for parents was based upon Tymchuk's (1978) concept of Parent and Family Therapy whereby parents require information, support and training to achieve the goals listed in Table 9. These goals all are now in keeping with BEH as well since they have come to recognize the importance of a total and continuous approach to interventions with the handicapped.

Parents received individual as well as group interventions where possible. Because of limited personnel and because of BEH's priority to provide child services first, the parent program was not as full as Dubnoff's staff recognizes that it should be in order to achieve optimal success. Perhaps in the future, if more funds are available, there will be greater parent involvement.

Not all parents were given all instruments since for some, the additional pressures of responding to sensitive issues and taking so much time would have coupled with the pressures of having a handicapped child, would have been to great. For those who did complete the materials their responses formed the basis of counselling sessions. Parents received the following packet which included:

Table 11 a	An Information Letter
Table 11 b	Parental Attitude Research Instrument (form 4)
Table 11 c	Questionnaire on Child Development
Table 11 d	Questionnaire on Handicapped Conditions
Table 11 e	Questionnaire on Attitudes
Table 11 f	Questionnaire on Resources
Table 11 g	Tennessee Self Concept Scale
Table 11 h	Connors Rating Scale

Some of the questionnaires were developed by A.J. Tymchuk and used here with his permission. Each of these was translated into Spanish and modified slightly from last year as a result of the data analysis then.

The pre-test results formed a needs assessment and these are listed in tables 12 a - 12 d. Two parent groups were run. There were 8 sessions of each of 90 minutes. The topics covered are listed in Table 13.

The actual contents of each are presented in Table 14 for use by others.

In addition to these two parent groups, there were ongoing individual consultations and home visits. Some parents also completed post-questionnaires. All results were very positive.

For one parent group there were 10 parents representing 7 children with an average attendance of 6 sessions. Four (4) of the parents were themselves mentally retarded. For the second group, there were 10 parents representing 10 children with an average attendance of 6 sessions.

dubnoff center for child development and educational therapy

Table 11 Information Letter

DEAR PROGRAM PARTICIPANT:

This package of questionnaires is the part of the Dubnoff Center service program which evaluates the quality and effectiveness of our service . The questionnaires are completed by the participants at the beginning and the end of the service program. Through your responses, it can be determined what effect our program has had with the people we provide service to.

It is important that all questions be answered, even though some may seem repetitous or irrelevant. They are all important for our evaluation. If you have difficulty answering a question, please feel free to request assistance from the person who gave you this packet.

We greatly appreciate your cooperation in filling out these questionnaires. Your responses and comments will be extremely valuable to us as we evaluate our service program.

In compliance with State and Federal regulations, all responses to these questionnaires are confidential, and will under no condition be released to any person not directly involved in our Evaluation.

The questionnaires included in this packet, as well as other evaluations during the year, are strictly for the purpose of Dubnoff's self-evaluation of program. If you should decline to participate, this would in no way effect the program provided to you and/or your child. Therefore, if you feel that you cannot participate in the Evaluation portion of the program, please advise the person who directs the program in which you are enrolled.

Again, thank you for your cooperation with this portion of our program. We are looking forward to sharing an exciting and successful year with you.

Sincerely,

Annette Y. Dahlman
Associate Executive Director

Ivy M. Mooring, Ph.D.
Executive Director

Table 11 b Parental Attitude Research Instrument

A QUESTIONNAIRE TO WOMEN (4)

Read each of the statements below and then rate them as follows:

A	a	d	D
Strongly Agree	Mildly Agree	Mildly Disagree	Strongly Disagree

Indicate your opinion by drawing a circle around the 'A' if you strongly agree, around the 'a' if you mildly agree, around the 'd' if you mildly disagree, and around the 'D' if you strongly disagree.

There are no right or wrong answers, so answer according to your own opinion. It is very important to the study that all questions be answered. Many of the statements will seem alike but all are necessary to show slight differences of opinion.

		Agree		Dis-agree	
1.	Children should be allowed to disagree with their parents if they feel their own ideas are better.	A	a	d	D
2.	A good mother lets her child learn the hard way about life	A	a	d	D
3.	A good mother should develop interests outside the home.	A	a	d	D
4.	A child should never be taught to fear adults.	A	a	d	D
5.	Parents shouldn't feel they have to sacrifice for their children.	A	a	d	D
6.	Mothers worry too much about bathing babies	A	a	d	D
7.	There is no reason for arguments in a happy marriage.	A	a	d	D
8.	Strict training will make a child resent his parents later on.	A	a	d	D
9.	There is no reason why a day with the children should be upsetting.	A	a	d	D
10.	Children have every right to question their mother's views	A	a	d	D
11.	Loyalty on the part of children to their parents is something that the parents should earn.	A	a	d	D
12.	Children should be taught to fight so they can take care of themselves.	A	a	d	D
13.	Taking care of a home doesn't have to coop a woman up.	A	a	d	D
14.	Parents should adjust to the children some, rather than always expecting the children to adjust to the parents.	A	a	d	D

15.	A child needs time to just sit around and do nothing if he feels like it.	A	a	d	D
16.	Children should be encouraged to talk about their problems	A	a	d	D
17.	Fathers generally are kind and helpful.	A	a	d	D
18.	Children should be taught about sex as soon as possible.	A	a	d	D
19.	It is not the mother's place to make the rules for the home.	A	a	d	D
20.	A child's thoughts and ideas are his own business.	A	a	d	D
21.	Children would be happier and better behaved if parents would show an interest in their affairs.	A	a	d	D
22.	Very few children are toilet trained by 15 months of age.	A	a	d	D
23.	A young mother doesn't need any help when going through her first experience.	A	a	d	D
24,	Children should be encouraged to tell their parents about it whenever they feel family rules are unreasonable.	A	a	d	D
25.	A child has to learn that he has to be disappointed sometimes.	A	a	d	D
26,	A good mother has an active social life.	A	a	d	D
27.	You can't make a child behave by cracking down on him.	A	a	d	D
28.	There is no reason why a mother can't be happy and make her child happy too.	A	a	d	D
29.	Most young mothers don't worry much about handling or holding the baby.	A	a	d	D
30.	A good wife never has to argue with her husband.	A	a	d	D
31.	Strict discipline makes children grow up to be mean or rebellious.	A	a	d	D
32.	Most mothers never get to the point where they can't stand their children.	A	a	d	D
33.	If a parent is wrong he should admit it to his child.	A	a	d	D
34.	A child should be taught that there are many other people he will love and respect as much or more than his own parents.	A	a	d	D

35. A child should be taught to fight his own battles. A a d D

36. Most mothers are content to be with children all the time. A a d D

37. Parents must earn the respect of their children by the way they act. A a d D

38. There is plenty of time for children to strive for success after they are older. A a d D

39. A child should always be encouraged to talk about his troubles. A a d D

40. Husbands have a perfect right to their own interests. A a d D

41. There is nothing wrong with bathing boys and girls in the same bath tub. A a d D

42. The family is better off when the husband settles most of the family problems. A a d D

43. Children are entitled to keep their own secrets. A a d D

44. Laughing at children's jokes and telling children jokes makes things go more smoothly. A a d D

45. A child should take all the time he wants before he walks. A a d D

46. Women should handle most of child raising without much help from others. A a d D

47. A child has a right to his own point of view and aught to be allowed to express it. A a d D

48. Children should be encouraged to undertake tough jobs if they want to. A a d D

49. A mother can keep a nice home and still have plenty of time left over to visit with neighbours and friends. A a d D

50. There is no need for children to look on parents as their bosses. A a d D

51. Most children are grateful to their parents. A a d D

52. Little accidents are bound to happen when caring for young children. A a d D

53.	If a couple really loves each other there are very few arguments in their married life	A	a	d	D
54.	If children are given too many rules they will grow up to be unhappy adults	A	a	d	D
55.	Most mothers can spend all day with their children and remain calm and even-tempered.	A	a	d	D
56.	A child should be encouraged to look for answers to his questions from other people even if the answers contradict his parents.	A	a	d	D
57.	Most children soon learn that their parents were mistaken in many of their ideas.	A	a	d	D
58.	It's quite natural for children to hit one another.	A	a	d	D
59.	Most young mothers don't mind spending most of their time at home.	A	a	d	D
60.	Children are too often asked to do all the compromising and adjustment and that is not fair.	A	a	d	D
61.	Children should have lots of time to loaf and play.	A	a	d	D
62.	A mother should be concerned with any problem of a child no matter how trivial.	A	a	d	D
63.	In most cases the mother rather than the father is responsible for trouble in the home.	A	a	d	D
64.	Sex play is a normal thing in children.	A	a	d	D
65.	A mother should take a back seat to her husband as far as the planning is concerned.	A	a	d	D
66.	A good parent doesn't try to pry into the child's thoughts.	A	a	d	D
67.	Parents who are interested in hearing about their children's parties, dates and fun, help them grow up right.	A	a	d	D
68.	A child needs to be emotionally close to its parents for a long time.	A	a	d	D
69.	A woman should be on her own after having a baby.	A	a	d	D
70.	A child's ideas should be seriously considered in making family decisions.	A	a	d	D

	Agree		Dis Agree	
71. Children have to face difficult situations on their own.	A	a	d	D
72. Mothers should get out of the home fairly often.	A	a	d	D
73. If a child acts mean he needs understanding rather than punishment.	A	a	d	D
74. Children don't "owe' their mothers anything.	A	a	d	D
75. Most mothers are confident when handling their babies.	A	a	d	D
76. Almost any problem can be settled by quietly talking it over.	A	a	d	D
77. Most children are disciplined too much.	A	a	d	D
78. Raising children is an easy job.	A	a	d	D
79. When a child thinks his parent is wrong he should say so.	A	a	d	D
80. A parent should not expect to be more highly esteemed than other worthy adults in their children's eyes.	A	a	d	D
81. Children should be taught ways of defending themselves in a fight.	A	a	d	D
82. If you can run your home right, you have plenty of time to do the things you like to do.	A	a	d	D
83. As much as is reasonable a parent should try to treat a child as an equal.	A	a	d	D
84. It isn't good for children to be constantly running from one activity to another.	A	a	d	D
85. A mother should always be concerned about upset feelings in a child.	A	a	d	D
86. Most husbands show a good understanding for a mother's problems.	A	a	d	D
87. Sex is no great problem for children if the parent doesn't make it one.	A	a	d	D
88. It's up to the father to take charge of the family.	A	a	d	D
89. Being a mother doesn't give women the right to know everything in their children's lives.	A	a	d	D

		Agree		Dis Agree	
90.	If parents would have fun with their children, the children would be more apt to take their advice.	A	a	d	D
91.	Toilet training should be put off until a child indicates that he is ready.	A	a	d	D
92.	A woman should be up and around a short time after giving birth.	A	a	d	D
93.	When a child is in trouble he aught to know he won't be punished for talking about it with his parents.	A	a	d	D
94.	Children should be encouraged to undertake all kinds of jobs no matter how hard.	A	a	d	D
95.	It is important for a mother to have a social life outside of the family.	A	a	d	D
96.	Children have a right to rebel and to be stubborn sometimes.	A	a	d	D
97.	Having children doesn't mean you can't have as much fun as you usually do.	A	a	d	D
98.	Mothers shouldn't worry much about calamities that might happen to their children.	A	a	d	D
99.	Husbands and wives who have different views can still get along without arguments.	A	a	d	D
100.	Strict training makes children unhappy.	A	a	d	D
101.	A mother should keep control of her temper even when children are demanding.	A	a	d	D
102.	A good mother can tolerate criticism of herself even when children are around.	A	a	d	D
103.	Loyalty to parents is an over-emphasized virtue.	A	a	d	D
104.	Most parents prefer a 'scrappy' child to a quiet one.	A	a	d	D
105.	Most young mothers are pretty content with home life.	A	a	d	D
106.	There is no reason parents should have their own way all the time anymore than that children should have their own way all the time.	A	a	d	D
107.	A child should have time to just dawdle or daydream.	A	a	d	D

		Agree		Dis agree	
108.	Anything a child wants to tell a parent is important enough to listen to.	A	a	d	D
109.	Most men try to take their wives out as often as they can.	A	a	d	D
110.	Children are normally curious about sex.	A	a	d	D
111.	Most wives think it best that the husband take the lead in family affairs.	A	a	d	D
112.	Every child should have an inner life which is only his business.	A	a	d	D
113.	When you do things together, children feel close to you and can talk easier.	A	a	d	D
114.	The longer a child is bottle or breast fed the more secure he will feel.	A	a	d	D
115.	Any woman should be able to take care of a baby by herself.	A	a	d	D
116.	Some children are just so bad they must be taught to fear adults for their own good.	A	a	d	D
117.	More parents should teach their children to have unquestioning loyalty to them.	A	a	d	D
118.	Children will get on any woman's nerves if she has to be with them all day.	A	a	d	D
119.	It is frequently necessary to drive the mischief out of a child before he will behave.	A	a	d	D
120.	The child should be taught to revere his parents above all other grown-ups.	A	a	d	D
121.	Mothers very often feel that they can't stand their children a moment longer.	A	a	d	D
122.	A wise parent will teach a child early just who is boss.	A	a	d	D
123.	A child soon learns that there is no greater wisdom than than of his parents.	A	a	d	D
124.	It's a rare mother who can be sweet and even-tempered with her children all day.	A	a	d	D
125.	Children need some of the natural meanness taken out of them.	A	a	d	D

		Agree		Dis agree	
126.	Parents deserve the highest regard and esteem of their children.	A	a	d	D
127.	Raising children is a nerve-wracking job.	A	a	d	D
128.	It is sometimes necessary for the parents to break the child's will.	A	a	d	D
129.	Loyalty to parents comes before anything else.	A	a	d	D
130.	It's natural for a mother to 'blow her top' when children are selfish and demanding.	A	a	d	D

Table 11 c

QUESTIONNAIRE ON CHILD DEVELOPMENT

DATE:_____ NAME:_____

Please indicate which answer you think is correct, by circling the letter of that response, or circling the entire word for the true and false questions.

1. Children will usually not begin walking until age:

   a. 2 years c. 6 months

   b. 10 months d. 1 year

2. Children will not crawl until:

   a. 6 months c. 10 months

   b. 2 months d. 1 year

3. A child will not begin eating solid (prepared) foods until:

   a. 2 years c. 2 months

   b. 6 months d. 1 year

4. You are the parent of two children. The first one sat alone at 3 months and walked at 10 months. The second sat alone at 8 months. He probably would walk at:

   a. 10 months c. 15 months

   b. 20 months d. 2 years

5. Children are not usually totally toilet-trained, that is, use the toilet for all elimination, until:

   a. age 1 year c. age 2 years

   b. age 6 months d. age 4 years

6. Children learn to walk before they say words: True False

7. Girls learn to walk earlier than do boys: True False

8. A child's diet is important in helping learning: True False

9. All children learn at the same speed: True False

10. Parents can help their children learn: True False

11. Children will copy what their parents do: True False

12. A child who has difficulty in moving his legs will probably learn to walk later than a child who can move his legs easily. True Fal

QUESTIONNAIRE ON CHILD DEVELOPMENT

13. By what age should a child be able to walk without assistance?_____

14. At what age should a child be able to copy a circle?_____years

15. By what age should a child be toilet trained?_____years

16. When should a child be able to tie a shoe lace? _____years

17. At what age does a child begin to play cooperatively with other children?_____years

18. When does a child begin to be afraid when separated from his/her mother?_____months

19. About how many words should a child know when they are 1 year old?_____

20. Between what ages does a child's speech develop the most rapidly? From_____to_____years.

21. By what ages should a child be able to count to 100?_____

22. By what age should a child be able to print her/his full name?_____year

23. By what age should a child be able to sleep through the night?_____year

24. When will a child smile responsively?_____months

25. When will a child begin to use words for what they mean?_____

26. At what age can a child correctly identify 2 colors?_____years

Table 11 d

QUESTIONNAIRE ON HANDICAPPING CONDITIONS

DATE:_____ NAME:_____

Please indicate your answer by circling the word "True" or "False"

1. All handicapping conditions of childhood come from the parents.

   True False

2. Having mental retardation means that a child will always have to be supervised by the parents.

   True False

3. Parents must give written permission before a child can be placed in a special class within a public school.

   True False

4. Some drugs can calm a child so that she/he can learn better.

   True False

5. When a child has difficulty walking, he/she usually has mental retardation.

   True False

6. A child will be healthier if the mother eats well during pregnancy.

   True False

7. Intelligence tests sometimes discriminate against minority groups.

   True False

8. Children who have difficulty in school can benefit from extra and special teaching.

   True False

9. The older the child is, the greater effect special teaching will have.

   True False

10. If a mother has one handicapped child, all of her children will have handicaps.

    True False

11. It would be alright for a pregnant woman to take unprescribed medications.

    True False

12. Children with behavior problems will not always have behavior problems if given special treatment.

True False

13. Persons with handicaps do not have the right to vote.

True False

14. All people, regardless of ability, have the right to appropriate treatment, services and habilitation.

True False

15. Parents of children with handicaps can help their children learn.

True False

16. Persons with mental retardation can become self-supporting.

True False

17. Children with mental retardation have to go to separate schools.

True False

18. The older a woman is when she has a baby, the greater is her chance of having a baby with handicaps.

True False

19. People with physical handicaps often also have mental retardation.

True False

20. Mental retardation means:

a. lower intelligence

b. an inability to take care of oneself

c. both a and b

Table 11 e

QUESTIONNAIRE ON ATTITUDES

DATE:_____ NAME:_____

Please circle the number which best describes your feelings:

1 you agree
2 you slightly agree
3 you are not sure if you agree or disagree
4 you slightly disagree
5 you disagree

The term "developmentally disabled" is used to refer to those persons who have a diagnosis of mental retardation, epilepsy, cerebral palsy or autism.

1.	Adults with a developmental disability are like children.	1 2 3 4 5
2.	Persons with a developmental disability should be allowed to vote.	1 2 3 4 5
3.	People with a developmental disability should not be allowed to have children.	1 2 3 4 5
4.	Being in the same class with developmentally disabled children will cause normal children to become developmentally disabled.	1 2 3 4 5
5.	All children with developmental disabilities come from poor families.	1 2 3 4 5
6.	There is no reason to fear people with developmental disabilities.	1 2 3 4 5
7.	People with a developmental disability can hold some kind of job that they can be paid for.	1 2 3 4 5
8.	Children with a developmental disability should not be allowed to play with children who do not have a developmental disability.	1 2 3 4 5
9.	People with developmental disabilities cannot live alone and take care of themselves.	1 2 3 4 5
10.	People with developmental disabilities should live in their own homes in the neighborhood.	1 2 3 4 5
11.	It would be alright for my child to attend school with developmentally disabled children.	1 2 3 4 5
12.	A child with a developmental disability can have a better life at home than in a special treatment program like the State Hospitals.	1 2 3 4 5
13.	It would be alright with me to have a friend	1 2 3 4 5

Table 11 f

QUESTIONNAIRE ON RESOURCES

DATE:_____ NAME:_____

Please write out your answer to the questions as asked. If you do not know the answer, please indicate "Don't Know", to indicate that you did not overlook the question. Thank you.

1. If your child was told she/he could not go to public school because of her or his disability, what would you do?

2. If your child vomits continuously, what would you do?

3. If your developmentally disabled son is 21 years old and lives at home, where could you apply for financial aid?

4. Name one agency which might help you find services for your child, if your child had mental retardation, epilepsy or autism.

5. If you wanted to speak to other parents who had a child with a difficul like your child's, what are the names of some parent organizations whon you could call?

6. Where is free medical care offered?

7. How could you find out which dentists will work with handicapped patients?

8. How can you get information on services available to you in your local community?

9. Name two services (other than financial assistance, Food Stamps or Medi-Cal) which the Welfare Department provides.

10. Name one agency that will act on your behalf when you are having difficulty obtaining services.

Table 11 g

TENNESSEE SELF CONCEPT SCALE

INSTRUCTIONS

On the top line of the separate answer sheet, fill in your name and the other information except for the time information in the last three boxes. You will fill these boxes in later. Write only on the answer sheet. Do not put any marks in this booklet.

The statements in this booklet are to help you describe yourself as you see yourself. Please respond to them as if you were describing yourself to yourself. Do not omit any item! Read each statement carefully; then select one of the five responses listed below. On your answer sheet, put a circle around the response you chose. If you want to change an answer after you have circled it, do not erase it but put an X mark through the response and then circle the response you want.

When you are ready to start, find the box on your answer sheet marked time started and record the time. When you are finished, record the time finished in the box on your answer sheet marked time finished.

As you start, be sure that your answer sheet and this booklet are lined up evenly so that the item numbers match each other.

Remember, put a circle around the response number you have chosen for each statement.

Responses-	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

You will find these response numbers repeated at the bottom of each page to help you remember them.

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Table 11 h

REGARDING YOUR CHILD IN THIS PROGRAM: Connors Rating Scale

	NEVER	RARELY	SOME OF
1. Picks at things (nails, fingers, hair, clothing).			
2. Sorry to grown ups.			
3. Problems with making or keeping friends.			
4. Excitable, impulsive.			
5. Wants to run things.			
6. Sucks or chews (thumb; clothing; blankets).			
7. Cries easily or often.			
8. Carries a chip on his shoulder.			
9. Daydreams.			
10. Difficulty in learning.			
11. Restless in the "squirmy" sense.			
12. Fearful (of new situations; new people or places; going to school).			
13. Restless, always up and on the go.			
14. Destructive.			
15. Tells lies or stories that aren't true.			
16. Shy.			
17. Gets into more trouble than others same age.			
18. Speaks differently from others same age (baby talk; stuttering; hard to understand).			
19. Denies mistakes or blames others.			
20. Quarrelsome.			
21. Pouts and sulks.			
22. Steals.			
23. Disobedient or obeys but resentfully.			
24. Worries more than others (about being alone; illness or death).			
25. Fails to finish things.			
26. Feelings easily hurt.			
27. Bullies others.			
28. Unable to stop a repetitive activity.			
29. Cruel.			
30. Childish or immature (wants help he shouldn't need; clings; needs constant reassurance).			
31. Distractibility or attention span a problem.			
32. Headaches.			
33. Mood changes quickly and drastically.			
34. Doesn't like or doesn't follow rules or restrictions.			
35. Fights constantly.			
36. Doesn't get along well with brothers or sisters.			
37. Easily frustrated in efforts.			
38. Disturbs other children.			
39. Basically an unhappy child.			
40. Problems with eating (poor appetite; up between bites).			
41. Stomach Aches.			
42. Problems with sleep (can't fall asleep; up too early; up in the night).			
43. Other aches and pains.			
44. Vomiting or nausea.			
45. Feels cheated in family circle.			
46. Boasts and brags.			
47. Lets self be pushed around.			
48. Bowel problems (frequently loose; irregular habits; constipation).			

49. If there are any additional comments on these questions or any remarks not covered – please elaborate below.

Table 12 a

Paernt Group Needs Assessment for Child Development

1. When a child begins to eat solid foods (2 mos.)
2. Children learn to say words before they walk.
3. Girls walk earlier than boys do.
4. A child should walk without help by 18-24 mos.
5. Children should tie a shoelace by 6 years (5).
6. Cooperation play begins at 4 years.
7. At one year, a child knows 2-3 words.
8. A child's speech develops most rapidly from 2-4 years.
9. A child should count to 100 by age 6.
10. A child should print her full name by age 6.
11. A child should sleep through the night at 1 year.
12. A child should smile responsively at 2-3 months.
13. A child should identify 2 colors by age 4.

Table 12 b

Parent Group Needs Assessment for Resources

1. If a child is excluded from public school due to a disability you should:
   a. contact the teacher, counselor and/or principal
   b. receive complete pupil evaluation
   c. receive recommendation to alternate programs
   d. receive funding for alternate program

2. Agencies to help find services for a disabled person: Regional Center, D.P.S.S., United Way.

3. Parent groups: NSAC, CAR, CEC, NARC, EPI, located through Regional Center.

4. Free medical care. Free clinic only. No charge to parent: Medi-cal, Regional Center.

5. Dentist who serve handicapped: Regional Center, D.P.S.S., Dental Association.

6. Service information: United Way, Regional Center, TRI.

7. Services of D.P.S.S. - placement, resources, counseling, emergency intervention, protective services, transportation.

8. Advocacy services: Western Center, Regional Center.

Table 12 c

Parent Group Needs Assessment for Handicapping Conditions

1. Parents must give written permission for special class placement in school.
2. Some drugs can calm a child so she/he can learn better.
3. A child will be healthier if the mother eats well during pregnancy.
4. Intelligence tests sometimes discriminates against minorities.
5. The earlier the intervention, the better.
6. Special treatment can alleviate behavior problems.
7. All people have a right to appropriate treatment.
8. Children with mental retardation are incorporated into regular schools.
9. The older the women during the pregnancy, the greater chance of handicap.
10. Mental retardation means lower intelligence.

Table 12 d

Needs Assessment for Attitude

1. Adults with a developmental disability are like children if they are treated like children

2. Some people with developmental disabilities can live alone and take care of themselves.

3. A child with a developmental disability can have a better life at home then in a placement facility.

Table 13

Session Topics

I.	Introduction, Filling out Questionnaires
II.	Discussion of how children learn, social learning theory. Discussion of observation techniques, home application.
III.	More detailed discussion of social learning theory, and individual application for each participant.
IV.	Discussion of normal child development: theories, stages, what to expect at what age.
V.	Discussion of handicapping conditions, how these effect expectations in view of normal child development, what are the handicapping conditions we should know about?
VI.	Discussion of attitudes regarding handicapping conditions, problems faced with family, friends, interested strangers.
VII.	Community resources: What are they, how to obtain services, what to do when services are not provided to eligible person. Advocacy, how it can benefit us.
VIII.	Review of material. Open discussion of any further topics in which participants are interested. Filling out questionnai

Curriculum for Parent Education Courses

Session One

I. Introduction
   - A. introduction of instructor and members of group
   - B. background leading to parent group program
   - C. what parent group includes
   - D. distribution and explanation of course outline
   - E. discussion of time and place for meetings

II. Questionnaires
   - A. explanation of purpose
   - B. distribution and review of questionnaire
   - C. discussion of time limits and any other restrictions

Curriculum for Parent Education Courses

Session Two

I. How Children Learn
   A. create list of survival needs of infant
      1. discuss research of infants without these survival needs
      2. discuss the similarities between child and adult needs
      3. inclusion of love
   B. create list of things children like
      1. this list will vary among groups due to individual differences
      2. inclusion of attention, praise, affection
   C. create list of things children dislike
      1. this list will vary among groups due to individual differences
      2. inclusion of being ignored, isolation, being hit, being slapped
      3. implication of the survival needs, likes and dislikes to behavior
   D. discussion of disciplining or teaching methods parents use and those they feel are effective
   E. theory of attention as a positive and negative reinforcer
   F. keys to effective parenting
      1. include consistency, consequences, understanding of rules

II. Observation Assignment
   A. observe child for the week
      1. list 3 things your child likes
      2. list 3 things your child dislikes
      3. pick a behavior you would like to increase or decrease in frequency
   B. optional assignment--on handout for session 3

Session Three

I. Social Learning Theory
   A. Review of session 2
      1. survival needs
      2. things children like
      3. things children dislike
      4. uses of attention
      5. effective parenting techniques
   B. discuss comparison of reinforcement and punishment
      1. use table IX in Dr. Tymchuk's book
      2. give examples of each of 4 situations
         a. giving something positive
         b. taking away something negative
         c. taking away something positive
         d. giving something negative
      3. formulate behaviors into target behaviors
      4. make a chart of the behavior
         a. define antecedent and consequence
         b. list the antecedent and consequences of a particular target behavior by questioning parent (teacher)
         c. discussion of what is occuring in antecedent and/or consequence which reinforces the frequency of behavior--the payoff
         d. discussion of restructuring of environment to change behavior
         e. rules in using positive reinforcement
         f. shaping
         g. generalization
         h. instrinsic and extrinsic motivation
         i. extinction
         j. time out
         k. punishment and its side effects
   C. observation assignment
      1. list behavior each parent (teacher) wants to increase or decrease in frequency

Session Four

I. Child Development
   A. review of last session
      1. follow up on each parent's (teacher's) plan and revisions drawn
      2. concepts
         a. how to analyze behavior
            1) target
            2) antecedent
            3) consequence
         b. positive reinforcement
         c. shaping
         d. generalization
         e. intrinsic and extrinsic motivation
         f. extinction
         g. time out
         h. punishment
   B. discussion of stages from 0-5, Erickson's model
      1. trust vs mistrust
         a. ease of feeding, sleep, relaxation of bowels
         b. consistency, continuity and sameness of experience connected to people
         c. the quality of the maternal relationship
      2. behaviors observed in children from 0-1-1/2 as seen in handout (child development)
      3. autonomy vs shame and doubt
         a. defining autonomy, shame and doubt
         b. cooperation and willfullness with examples
         c. self expression and supression
         d. issue of toilet training
      4. behaviors observed in ages 1-1/2-3 as seen in child development handout
      5. initiative vs guilt
         a. undertaking, planning and attaching a task--initiating
         b. guilt connected to feelings, jealousy, sexuality
      6. behaviors observed in ages 3-5

Session Five

I. Handicapping Conditions
   A. review of child development
      1. Erickson's theories
         a. trust vs mistrust
         b. autonomy vs shame and doubt
         c. initiation vs guilt
      2. behaviors observed in different ages
      3. how parents can be effective teachers
   B. Developmental disabilities
      1. definition
      2. handicapping conditions under this label
         a. autism
         b. epilepsy
         c. mental retardation
         d. cerebral palsy
   C. Autism
      1. what autism is
      2. the incidence of autism in population
      3. the causes
      4. the effects of autism on normal development
      5. the management and treatment
      6. film--Bobby
         a. reactions to film
         b. how and what we know about autism refers to film
   D. Epilepsy
      1. what epilepsy is
      2. the incidence of epilepsy in the population
      3. the causes
      4. the effects of epilepsy on normal development
      5. the management and treatment
      6. film--Images of Epilepsy
         a. the 3 types of seizures and their effects on functioning
         b. emotional problems surrounding epilepsy and lack of diagnosis
      7. handouts

Session Five -- continued

E. Mental retardation
   1. what is mental retardation
   2. the incidence of mental retardation in the population
   3. the causes
   4. Down's Syndrome
   5. the effects of mental retardation on normal development
   6. the management and treatment
   7. slides on early intervention program
   8. handouts

f. Cerebral palsy
   1. what is cerebral palsy
   2. the incidence of cerebral palsy in the population
   3. the causes
   4. the effects of cerebral palsy on normal development
   5. the management and treatment
   6. film--The Hurricane Inside
   7. handouts

Session Six

I. Discussion Questions
   A. Who or what is responsible for developmental disabilities?
      1. parents
      2. drugs
      3. age of mom
      4. nutrition
      5. general causes
   B. To what extent can developmental disabled persons be independent?
      1. hold a job
      2. vote
      3. get married
      4. have a family
      5. live by themselves
      6. care for themselves
   C. What can help a child with a development disability?
      1. drugs
      2. special education
      3. early intervention
      4. parents
   D. What are the fears in associating with persons with developmental disabilities?
      1. attending the same school or class
      2. having them as a friend or playing with them
      3. catching it

Curriculum for Parent Education Courses

Session Seven

I. Community Resources
   A. Things to do if your child is denied placement in a public school because of his/her disability
      1. questions to ask teacher, school counselor and/or principal
      2. questioning of psychologist on staff at your local area office
      3. questioning at Board of Education
   B. Where and how to have an evaluation done on the child in question
      1. agencies
      2. process involved
   C. Agencies which might help you find services for your child if he/she is developmentally disabled
   D. Parent organizations that you could call to speak to other parents with similar problems
   E. Agencies that can refer you to doctors and dentists that work with the handicapped
   F. Places to call that will give you information on services available in your local community
   G. Where to obtain free medical care
   H. What to do in a medical emergency
   I. The services the welfare department provides

II. Advocacy
   A. Agencies that will act on your behalf if you encounter difficulty obtaining services
   B. PL 94-142
   C. The Master Plan of California
      1. due process
      2. parent involvement
      3. what it provides
      4. differences from other legislation
      5. question and answer session

Curriculum for Parent Education Courses

Materials Distributed or Used and Their Sources

I. Pamphlets and books

A. "Could Your Child Be Autistic"
"Children Apart"
National Society for Autistic Children
169 Tampa Ave.
Albany, N.Y. 12208

B. "Answers to the Most Frequent Questions People Ask About Epilepsy"
"Because You Are My Friend"
"Epilepsy--the Teacher's Role"
"Teacher Tips About the Epilepsies"
"You, Your Child and Epilepsy"
"Epilepsy School Alert"
"Benjamin"
Los Angeles County Epilepsy Society
2911 West 8th Street
Los Angeles, CA 90005

C. "Behavior Modification With Children"
Alexander Tymchuk, Ph.D.
Charles Thomas, publisher
Springfield, Illinois

D. Information on Resources
prepared by Nora Baladerian
Dubnoff Center

E. "What is Cerebral Palsy"
"Cerebral Palsy" -- Facts and Figures
United Cerebral Palsy Association
Los Angeles Affiliate
14651 Titus Street
Van Nuys, CA 91402

F. "A Handicapped Child in Your Home"
U.S. Department of Health, Education and Welfare
Office of Child Development
HEW Publication No. (OCD) 73-29
"Your Child From 1-3 (OCD) 73-56
"Your Child From 3-4 (OCD) 72-57
"Your Child From 1-6 (OHD) 76-30026
"Your Baby's First Year" (OCD) 72-54
"Child Development in the Home" (OHD) 76-30042
Also from HEW Publications

Materials Distributed or Used and Their Sources -- continued

F. continued-- Social Development in Young Children
"Caring for Children"
The Ways Children Learn (OHD 75-1026)
More Than a Teacher (OHD 73-1027)
Preparing for Change (OHD 76-31028)
Away From Bedlam (OHD 76-31029)
The Vulnerable Child (OHD 76-31030)
A Setting for Growth (OHD 76-31031)
The Individual Child (OHD 76-31032)
From I to We (OHD 74-1033)
Conditions for Learning (OHD 74-1034)
Language is for Communication (OHD 76-31035)

G. Summary of Development Milestones
adapted from Nusse, Conger and Kagan

H. "When Your Child is Unruly"
Ross Laboratories
Columbus, Ohio

I. "Los Angeles Regional Center"
"Newsletter"
"California Master Plan for Special Education"
"What is Mental Retardation"--Pacific State Hospital
L.A. Regional Center
Van Nuys, California

II. Films and slides

A. "Bobby"
obtained through National Society for Autistic Children, Los Angeles Chapter

B. "The Hurricane Inside"
"Dream for Tomorrow"
"Walking in the Sunshine"
obtained through Los Angeles Cerebral Palsy Assoc.
1465 Titus Street
Van Nuys, CA 91402

C. "Images of Epilepsy"
"For Those Who Teach"
obtained through Los Angeles County Epilepsy Society
2911 West 8th Street
Los Angeles, CA 90005

D. "The Parent As a Teacher"

E. "Childhood, The Enchanted Years"
obtained through Northridge University

Results with Parents

Table 19 contains the results for one parent group for Child Development, Handicapping Conditions and Resources. The parents showed significant improvement on the first and last, but interestingly, they knew a great deal about the handicapping conditions. The contrast group made up of mothers who volunteered from the same schools also were families with handicapping conditions.

Table 14

Parent Group Results (Average Correct) Contrast

	Parent Group		Contrast	
	Pre	Post	Pre	Post
Child Development (26 questions)	12.3	16.3*	13.8	14.7
Handicapping Conditions (20 questions)	17.8	18	17.2	16.2
Resources (10 questions)	1.7	3.5*	1.9	3.1

* $p=<.05$

C Program with Teachers

The program goals for teachers are presented in Table 15 .

In addition to individual consultations three (3) courses were presented. Two were given under the auspices of the Health Training Center for continuing education credit and through Dubnoff. The topics were from a needs assessment of the areas served (Table 16).The topics given are listed in Tables 17 and 18. One course was given at Dubnoff and the other at Harbor Regional Center so as to be accessible to teachers in the two areas.

All participants were given questionnaires shortened from the parental ones, developed by Dr. A. J. Tymchuk and used here with his permission:

Table 18a Questionnaire on Normal Child Development
Table 18b Questionnaire on Handicapping Conditions
Table 18c Child Abuse - Legislation
Table 18d Questionnaire on Attitudes
Table 18e Social Learning Questionnaire
Table 18f Social Learning Pictures

All sessions were evaluated using the form in Tables 20 and 21.

Table 15

Goals with Teachers: How Evaluated and Intervention Strategies

Goals	How Assessed	Intervention
I. To improve special educational skills in the following areas: a. identification of handicapped children b. evaluation of abilities of these children c. development of remedial educational programs for these children d. implementation of remedial programs for these children	Pre-post questionnaires. a. consultant observations b. consultant observations c. analysis of pre-post written reports; videotapes of reqresentative cases d. consultant observation of teachers implementation; videotapes of representative cases	Individual consultation in teachers' classes.
II. To develop realistic attitudes toward handicapped children	Pre-post questionnaire on attitudes toward the developmentally disabled.	Two college and continuing education-credited 8 week courses.
III. To increase knowledge regarding handicaps in the following areas: a. normal child development and how handicaps can change this development b. resources for the handicapped c. laws relating to the handicapped d. parents of the handicapped e. types of handicaps	Pre-post questionnaire on handicaps	Same as above.

Table 16

IN-SERVICE NEEDS QUESTIONNAIRE

Following is a list of topics which we can offer for in-service training It is by no means exclusive, but rather is meant as a springboard for ideas and a checklist, so that we can plan to provide in-service presentations that meet your needs and interests.

Please indicate your preferences, by prioritizing your top 3 choices among the categories. At the bottom there is a space for you to add your own ideas.

Thank you for your help with this survey. The prompt return of these surveys will assist us by giving us ample time to establish a plan for meeting your needs.

I. CLASSROOM MANAGEMENT

_____1. transition times
_____2. providing individual attention during class time
_____3. providing a quiet corner
_____4. interest centers: how to go about creating
_____5. appropriate use of "free time"
_____6. guiding choice making processes
_____7. successful daily programming & environmental structuring
_____8. working together as a team to provide consistent programming
_____9. Mainstreaming: Integrating children with special needs into your classroom
_____10. Working with parents in the classroom
_____11. Working with aides and volunteers successfully for your progr
_____12. Developing successful & workable individual education plans (
_____13. Dealing with separation
_____14. More about developmental progress
_____15. Using positive reinforcement in the classroom for behavior, self-esteem, feeling better.
_____16. Self-Concept development
_____17. Questioning techniques: How to elicit information in a way t pleases both of you

II. INDIVIDUAL CHILDREN

_____1. agression
_____2. emotional disturbance
_____3. withdrawal
_____4. shyness
_____5. no speech
_____6. swearing
_____7. hyperactivity
_____8. short attention span
_____9. child abuse
_____10. stubborn
_____11. the possibly delayed child...what to do?
_____12. being gifted
_____13. How do you know hwen a child needs special help? (Assessment and observation techniques)

Please list any other areas that are of concern to you, which you would like for the topic for in-service training:_____

"ASSESSMENT AND INTERVENTION STRATEGIES FOR WORKING WITH THE PRE-SCHOOL CHILD WITH DEVELOPMENTAL DISABILITIES"
(X11-4q)

A course of training presented through the cooperation of the Dubnoff Center for Child Development and Educational Therapy, and the Health Training Center, Los Angeles.

DATE: March 27 through May 22
TIME: 2:00 - 4:00 P.M.
LOCATION: Dubnoff Center, 10526 Victory Place, North Hollywood (984-3604)
COORDINATOR: Ivy M. Mooring, Ph.D.

SCHEDULE OF LECTURES

March 27, 1978	Normal Stages of Development	Richard Koch, M.D. C.H.L.A. - Children's Hospital of Los Angeles
April 3, 1978	Observation & Recording of Behavior: Non-Standardized Techniques	Alexander Tymchuk, Ph.D. Assoc. Professor of Psychiatry, U.C.L.A.
April 10, 1978	Assessment Techniques for Measuring Changes in Behavior	Antoinette Hudson, Ph.D. L.A. County Schools Headstart 9300 E. Imperial Hwy. Downey, 90242
April 17, 1978	Abnormal Development - Recognition & Intervention	Bruce Littman, M.D.. Developmental Pediatrici
April 24, 1978	Intervention Strategies for Behavior	Alexander Tymchuk, Ph.D.
May 1, 1978	Intervention Strategies for Learning	Panel: Dubnoff Center St Sarah Moskovitz, Ph.D., Consultant Susan Bredhoff, M.Ed., Outreach Consultant Pam Segrist, M.S., Infant Specialist Charlene Harbert. Sensori-Motor Special Joy Zimnavoda, M.A., Educational Therapist

May 8, 1978	Legislation - Current Trends and Changes; Child Advocacy	Valerie Vanaman, Atty.
May 15, 1978	Community Resources and Child Abuse	Nora Baladerian, B.A. Outreach Consultant Morris Paulson, Ph.D. U.C.L.A.
May 22, 1978	Individual Education Plans	Alexander Tymchuk, Ph.D.

Table 18

"ASSESSMENT AND INTERVENTION STRATEGIES FOR WORKING WITH THE PRE-SCHOOL CHILD WITH DEVELOPMENTAL DISABILITIES"

A course of training presented through the cooperation of the Dubnoff Center for Child Development and Educational Therapy, and the Health Training Center, Los Angeles.

DATE: March 30 through May 25 (Thursdays)
TIME: 2:00 - 4:00 P.M.
LOCATION: Harbor Regional Center - 20620 Leapwood Avenue, Suite "K", Carson (323-3030)
COORDINATOR: Ivy M. Mooring, Ph.D.

SCHEDULE OF LECTURES

March 30, 1978	Normal Stages of Development	Bruce Littman, M.D., Pediatrici Specialty: Developmental Disabil:
April 6, 1978	Observation and Recording of Behavior: Non-standardized Techniques	Alexander Tymchuk, Ph.D. Associate Professor of Psychiat U.C.L.A.
April 13, 1978	Assessment Techniques for Measuring Changes in Behavior: Standardized Techniques	Antoinette Hudson, Ph.D. Mental Health Consultant L.A. County Schools Headstart
April 20, 1978	Abnormal Development: Recognition and Intervention	Mario Valente, M.D. Staff Pediatrician, U.C.L.A.
April 27, 1978	Intervention Strategies for Behavior	Alexander Tymchuk, Ph.D.
May 4, 1978	Intervention Strategies for Learning	Panel: Dubnoff Center Staff: Annette Dahlman, M.S. Associate Executive Directo: Susan Bredhoff, M.Ed. Outreach Consultant Pam Segrist, M.S. Infant Specialist Charlene Harbert Sensori-Motor Specialist Joy Zimnavoda, M.A. Educational Therapist

-over-

May 11, 1978	Child Care Legislation and Child Advocacy	Valerie Van aman , Attourney Legal Aid Foundation
May 18, 1978	Community Resources	Nora Baladerian, B.A. Outreach Consultant
	Child Abuse	Morris Paulson, Ph.D. U.C.L.A.
May 25, 1978	Individual Education Plans	Alexander Tymchuk, Ph.D.

QUESTIONNAIRE ON NORMAL CHILD DEVELOPMENT

DATE:_____ NAME:_____

1. By what age should a child be able to walk without assistance?

   By _____ months

2. By what age should a child be toilet trained?

   By _____ years

3. When should a child be able to copy a circle?

   By _____ years

4. At what age does a child begin to play cooperatively with other children?

   By _____ years

5. Between what ages does a child's speech develop the most rapidly?

   From _____ to _____ years

6. By what age should a child be able to sleep through the night?

   By _____ years

Table 19b

NAME_____

HANDICAPPING CONDITIONS

1. The thinking process of brain damaged children is characterized by:

   a. abstractness
   b. concreteness
   c. flexibility
   d. all of these

2. The language autistic children is characterized by:

   a. echoing
   b. stereotyped utterances
   c. no social communication
   d. all of these

3. The main characteristic of cerebral palsy is:

   a. hereditary
   b. disease of childhood
   c. lack of oxygen to the brai
   d. mental retardation

4. Epilepsy is known to be:

   a. hereditary
   b. contraindication for pregnancy
   c. contagious
   d. usually controlled medical

5. Society can reduce handicapping by:

   a. minimizing segregation of the different person
   b. eliminate ineffectual diagnostic techniques
   c. eliminate labeling
   d. none of the above
   e. a and c

Table 19d

QUESTIONNAIRE ON ATTITUDES

DATE:_____ NAME:_____

Please circle the number which best describes your feelings:

1 you agree
2 you slightly agree
3 you are not sure if you agree or disagree
4. you slightly disagree
5. you disagree

The term "developmentally disabled" is used to refer to those persons who have a diagnosis of mental retardation, epilepsy, cerebral palsy or autism

1.	Adults with a developmental disability are like children.	1 2 3 4 5
2.	Persons with a developmental disability should be allowed to vote.	1 2 3 4 5
3.	People with a developmental disability should not be allowed to have children.	1 2 3 4 5
4.	Being in the same class with developmentally disabled children will cause normal children to become developmentally disabled.	1 2 3 4 5
5.	All children with developmental disabilities come from poor families.	1 2 3 4 5
6.	There is no reason to fear people with developmental disabilities.	1 2 3 4 5
7.	People with a developmental disability can hold some kind of job that they can be paid for.	1 2 3 4 5
8.	Children with a developmental disability should not be allowed to play with children who do not have a developmental disability.	1 2 3 4 5
9.	People with developmental disabilities cannot live alone and take care of themselves.	1 2 3 4 5
10.	People with developmental disabilities should live in their own homes in the neighborhood.	1 2 3 4 5
11.	It would be alright for my child to attend school with developmentally disabled children.	1 2 3 4 5
12.	A child with a developmental disability can have a better life at home than in a special treatment program like the State Hospitals.	1 2 3 4 5
13.	It would be alright with me to have a friend with a developmental disability.	1 2 3 4 5

Table 19c

CHILD ABUSE - CHILD CARE LEGISLATION

1. One of the formost characteristics of the parent of a child who is being abused is
   a) not married
   b) cold, hostile
   c) many children
   d) were abused themselve

2. One way to be the most helpful to the parent suspected of child abuse is
   a) ignore the problem
   b) report to police
   c) refer to Parents Anonymous
   d) discuss concerns dir with the parent

3. What current legislation authorizes free and appropriate educational opportunity for all children regardless of handicap?

   _____

4. What is the major legislation in the State of California th: addresses child care concerns?

   _____

Table 19e

SOCIAL LEARNING QUESTIONNAIRE

1. The most effective method way to strengthen (increase) a child's behavior is to:

   a. tell her to do it again
   b. praise her
   c. ignore her
   d. suggest another activity

2. The most effective means of decreasing a child's behavior of screaming is to:

   a. tell him to stop it
   b. threaten him
   c. ignore him
   d. offer candy if he'll stop

3. The main factor that determines if a behavior will continue or not is:

   a. if the behavior is good for you
   b. how much the person likes to engage in the behavior
   c. the consequence of the behavior
   d. if the person considers it to be "right" behavior

4. Punishment _____ behavior.

   a. strengthens
   b. rewards
   c. reinforces
   d. weakens

5. Reinforcement _____ behavior.

   a. strengthens
   b. weakens
   c. increases probability of
   d. a and c only

6. Everytime Jimmy screams, even when he is not hurt, his mother cuddles him. She is_____.

   a. punishing good behavior
   b. punishing bad behavior
   c. reinforcing good behavio
   d. reinforcing bad behavior

7. In the above example the mother complains to her husband that Jimmy "just won't mind her anymore." What could she do to get Jimmy to listen to her and not to scream?

   a. Give him food for screaming.
   b. Take away food when he listens.
   c. Praise him when he listens and ignore him when he screams.
   d. Praise him when he screams and ignore him when he listens.

Table 19f

Social Learning Pictures

1

85

CHILD THROWS GLASS ON FLOOR

A. What you would do?_____

B. When you would do it?_____

86

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A. What you would do?_____

B. When you would do it?_____

87

CHILD IN PLAYROOM, TEARS UP BOOK

88

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89 CHILD PURPOSELY POURS TOO MUCH SALT ON DINNER

A. What you would do?_____

B. When you would do it?_____

90

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7

91

CHILD SCREAMS IN MIDDLE OF PLAYROOM

A. What you would do?_____

B. When you would do it?_____

92

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8

Child rides quietly in store basket while mother shops

93

A. What you would do?_____

B. When you would do it?_____

94

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95

CHILD TUGS AT MOTHER WHILE SHE'S COOKING

A. What you would do?_____

B. When you would do it?_____

96

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13

Child picks up toys

A. What you would do?_____

B. When you would do it?_____

97

98

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99 Child hangs up jacket in closet

A. What you would do?_____

B. When you would do it?_____

100

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16

class that is wild

101

A. What you would do?_____

B. When you would do it?_____

102

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Table 20 TALLY

FINAL COURSE EVALUATION

Course No. XII-4q - Dubnoff Date May 22, 1978 Title Assessment & Intervention Strategies for Working wi The Pre-School Child with

Coordinator Ivy Hooring, Ph.D.

1. Please rate your knowledge gain from this course and the usefulness of that knowledge to you in your work by circling the appropriate number on the seven point scales.

KNOWLEDGE GAIN (None 1 2 3 4 5 6 7 A Great Deal)

Total N = 23
Median = 6

n= 0	n= 1	n= 1	n= 1	n= 6	n= 5	n= 9
%= 0	%= 4	%= 4	%= 4	%= 26	%= 22	%= 39

USEFULNESS (None ..... A Great Deal)

Total N = 20
Median = 5.5

n= 0	n= 0	n= 2	n= 3	n= 5	n= 4	n= 6
%= 0	%= 0	%= 10	%= 15	%= 25	%= 20	%= 30

2. Did this event allow adequately for you to:

a. Participate in planning its contents? YES 14 NO 6

b. Interact with the guest speaker? YES 22 NO 1

c. Get help with your questions? YES 23 NO 0

3. What specific topics not included in this event would you suggest be included the next time the course is given? Please indicate, if you can, your candidate to present each topic.

Working with parents - Susan Bredhoff. Infant and toddler development (normal & adnor Pam Segrist.
More information on how to handle "problem" (behavior) child not "disturbed", emotiona disturned child.
Give more visual examples with lecture presentation.

4. Now that you have completed this training event, which, if any, of the following do you expect to occur attributable, at least in part, to this learning experience

15 increased professional competence

15 improved service delivery

13 anticipation of new services

18 improved communication with other agencies concerned with the same or related services as your agency provides

17 more comfort in my present job

7 other

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5. Given all the conditions of your current job, do you feel as though you are fun... effectively in your professional role? Mostly Yes 22 Mostly No 1

6. Additional Comments:

Great series. I would enjoy hearing it all again. So much to absord (almost). I pl to go over all notes and pass-out to organize and present over view to my school.
Excellent series - presenters very competent.
I learned a lot from this class and if there is a continued class from this I would l to know about it and attend.
As a social worker I found it offered helpful information in terms of making adequate referrals for various evaluations of children that we see.
I believe this course was very helpful especially to teachers in headstart who have n had this background.
Some of the speakers were speaking higher than I could make use of, for example, Dr. Hudson - too complicated, more history, pediatricians - excellent background, lea awful lot, very stimulating. Nora B. - new knowledge, I learned an awful lot, abo when to go, how to. Panel of 5 was an excellent session.
I appreciate hearing from people who work with kids and parents out of the classroom. Sawyer, consultant - because I get a different perspective on the problems I have deal with.
Sime session really need a break period. I enjoyed the scope of the course and benef from the related services information.

9. We are planning a follow-up study to assess the ways in which experience in the Center curriculum may be translated into the service delivery system. If you consent to participate, you will be contacted in approximately three months and given the opportunity to share with us freely your opinion, and your professional experience during the intervening 3 months that shaped your opinion, regarding the usefulness of this learning experience.

Do you consent to be included in the follow-up study? YES 11 NO 7

Table 21 TALLY

FINAL COURSE EVALUATION

Course No. XII-4p - Harbor Date May 25, 1978 Title Assessment & Intervention Strategies for Working wi The Pre-School Child with

Coordinator Ivy Mooring, Ph.D.

1. Please rate your knowledge gain from this course and the usefulness of that knowledge to you in your work by circling the appropriate number on the seven point scales.

KNOWLEDGE GAIN (None ..... A Great Deal)

	1	2	3	4	5	6	7
Total N = 40	n= 0	n= 0	n= 0	n= 2	n= 11	n= 13	n= 14
Median = 6.	%= 0	%= 0	%= 0	%= 5	%= 28	%= 33	%= 35

USEFULNESS (None ..... A Great Deal)

	1	2	3	4	5	6	7
Total N = 33	n= 0	n= 0	n= 0	n= 4	n= 6	n= 12	n= 11
Median = 6.	%= 0	%= 0	%= 0	%= 12	%= 18	%= 36	%= 33

2. Did this event allow adequately for you to:

a. Parcicipate in planning its contents? YES 16 NO 20

b. Interact with the guest speaker? YES 35 NO 4

c. Get help with your questions? YES 37 NO 1

3. What specific topics not included in this event would you suggest be included the next time the course is given. Please indicate, if you can, your candidate to present each topic.

The panel we had was more practical for me as a teacher.
I would like to see more on child abuse, including the sexually abused child. I know a couple of good speakers in this field and will be writing to you about some new conferences in this field.
More Dr. M. Valente.
Reinforcement of acceptable behavior. Dr. Tymchuk.
A survey of DD diagnoses, causes and prognoses.
A specific section on speech disabilities including the asphosic child. A specific section on learning disabilities - perceptual problems.
Dr. Tymcheck's, Dr. Paulson's, Dr. Valente's presentation.
What is to be done in terms of education for the developmental, disabled over the age 21 years.
A non-labeling process for at risk or minimally handicapped children while still providing needed services to forestall more serious handicaps.
Session on self awareness of persons feelings re: dev. diabled. Practical case exam solicited none class. More knowledge re: classification of the dev. disabled. Eliminate session on normal growth and development. This should be a pre-requisi for the course.
Not so much basic child growth and dev. and more specific [illegible] handling a DD child.
Topics included were of interest to me.

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-4p - Harbor
May 25, 1978
Ivy Mooring, Ph.D.
Assessment & Intervention Strategies for
Working with The Pre-School Child with DD

4. Now that you have completed this training event, which, if any, of the following do you expect to occur attributable, at least in part, to this learning experience?

29 increased professional competence

17 improved service delivery

11 anticipation of new services

20 improved communication with other agencies concerned with the same or related services as your agency provided

21 more comfort in my present job

1 other

0 N/A

5. Given all the conditions of your current job, do you feel as though you are functionin effectively in your professional role? Mostly Yes 33 Mostly No 2

6. Additional Comments:

I feel it was most important training and provided much information that I didn't have but should have related to my job.
I enjoyed the workshop on lectures.
Each guest speakers were thorough in the specified subjects. Each session was done outstanding. The Dubnoff group was quite informative.
During each session lecturer can make a comparison of the normal vs the disabled chil
Self awareness - people believe, think and feel differently about an issue or per
All the speakers were interesting and informative. They all did an outstanding job.
Well planned.
Class was very good.
Class was very good and helpful.
This subject or course is very important to me for my job and not only to my job but I can also apply at home to my children whose ages are 6 & 8 years old.
Speakers were very good and I enjoyed the lectures very much. I felt that lots of wo was done in the planning.
The panel was not particularly useful to me.
The program I found least helpful was the educational team. Perhaps a team explainin how the pre-school child with specific problems can be helped would be beneficial
I am a foster parent. I wish that foster parents could get more training so that we know how to work with our children. There needs to be more training in coping wi the emotionally abused child as well as the physically abused child, as I feel th problem can cause a developmental disability.
Appreciated all the handouts. Will be able to use knowledge gained in inservices for nurses aids.
Some of the sessions were not presented as well as others. One particular speaker tu me completely off because she used profanity. I feel that one especially a lady, should refrain in situation such as these.

7. Do you consent to be included in the follow-up study? YES

RECEIVED
JUN 22 1978

In addition to the above 2 courses, another course was given to 18 CETA workers as part of the Outreach program. The topics presented were similar to those for the teachers since the CETA workers were working in Head Start. There were 8 sessions of 90 minutes each with all receiving full questionnaires on Child Development, on Handicapping Conditions and on Resources before the course, after the course and again 2 months after the end of the course to determine how much information was retained.

Table 22 contains the results of the CETA training program. The data show that for child development information, where the participants knew 11.6 of the answers before the course, they knew 18.6 answers at the end and 15.2 two months later. There was not a significant increase in knowledge of handicapping conditions, but there was on resources and this increase was maintained.

Table 22

CETA Training Program Results

(Mean Correct)

	Pre	Post I (8 weeks)	Post II (16 weeks)
Child Development Knowledge (26 questions)	11.6	18.6*	15.2
Knowledge of Handicapping Conditions (20 questions)	16.3	17.4	17.6
Knowledge of Resources (10 questions)	12.2	17.1*	17.1

*P=<.05

Table 23

Results for Teachers Courses (Average Correct)

	Pre	Post
Child Development (6 questions)	2.4	2.4
Handicapping Conditions (5 questions)	2.8	3.8
Child Abuse - Legislation (4 questions)	2	2.3
Social Learning Principles (7 questions)	5.7	6.1
Social Learning Examples (9 questions)	4.6	6.9*

* P=L.01

Table 23 contains the results with the teachers courses. Using the shortened versions of the questionnaires, there was not any significant knowledge gain except for social learning principles. Future evaluation must balance time factors as well as having a broad enough sampling of issues.

Conclusion

The previous data indicate that Dubnoff's programs, both for the Offsite and Onsite portions, were very successful. Future efforts, if funding continues, would continue to focus upon the use of multiple baseline evaluation procedures and for provision of services to parents and to teachers.

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Certificate

Awarded To

_____

For Successful completion of an eight week course covering: effective parenting techniques, handicapping conditions and community resources.

This ____ day of _____ 197

_____ _____

Certificado de Terminación

Este certificado significa que

_____

ha completado el curso de padres sobre el entrenamiento, desabilidad de desarrollo y desarrollo normal del niño.

El dia ____ de _____ 197.

_____ _____

VIDEOTAPE CODING SYSTEM

In Collaboration with Carol Bellamy, Alan Insul, Danielle Berger

This coding system is a device for assessing a child's behavior in a standard manner. It covers behaviors across two broad dimensions: 1) elicited, that is, responses such as following directions that occur in context with social cues and 2) spontaneous, those responses that the child emits alone or with another that are not directly cued by another person.

These dimensions of a child's behavior are coded in three situations:

Section I. The child with his parent
Part A, Elicited Behavior
Part B, Spontaneous behavior

Section II. The child alone-spontaneous behavior

Section III The child with a teacher
Part A, Elicited Behavior
Part B, Spontaneous Behavior

On the form, mother, father and teacher are referred to as trainers.

CODING CONVENTIONS

Coding is done in terms of both duration and frequency.

Duration: On each part of the form, behaviors that are to be recorded in terms of duration are listed at the top of the page and are followed by four lines of boxes. Each box stands for a 5 second unit of time. A single line permits coding of behavior up to three minutes duration. Twelve minutes of behavior can be recorded on the four lines allowed for a single behavior.

Example: To code duration of a temper tantrum, use a stop-watch, flick on as the tantrum begins. On the coding sheet, check a box every 5 seconds that the behavior lasts. When the child stops, mark T for "terminates" in the box that corresponds to the time unit in which cessation of the tantrum occurred. If the child begins to tantrum once more, return the watch to zero, begin timing and checking in the next box for that behavior. If the tantrum is of short duration, a duration of 1 second should be recorded.

Frequency-Elicited Behavior: Following directions is coded in terms of number of directions given in relation to number and type of responses. A direction from the trainer is coded as a slash mark. For multiple requests of the same direction, each is coded as a separate slash. When the child responds, place a bar next to the tallies for that direction and code the child's response in one of the following ways:

Correct Response: (R) is defined as one that is appropriate to the just preceding verbal cue. Partially correct or random responses are not scored.

Incorrect Response: (IR) is one which is not correct in view of the preceding verbal cue.

No Response:(NR) is coded when the verbal cue elicits no response which appears to be related to the preceding verbal cue. Code NR when the trainer switches to a new instruction or activity.

Frequency-Other: Aside from these sections, frequencies are recorded in the usual way with tally marks.

Note: In taking either kind of tally, record trainer's verbal cue which is accompanied by some kind of demonstration (pointing, modeling) as a slash with a dot below (1).

Note: In coding for direction following, some leeway with the exact wording of the direction may be allowed. "Hands down" may be considered equivalent to "Hands in lap" or "Come here" as the same as "Come to me".

GENERAL BEHAVIORAL DEFINITIONS

Temper Tantrums: crying or screaming with or without accompanying physical activity (pounding, stamping feet, struggling when physically restrained).

Verbalization: recognizable utterances, not including vocalizations. Code separately for single words, phrases, sentences, echolalia and pronominal reversals.

Self-Stimulation: physical; repeated, stereotyped gestures or body movements that occupy the child's attention. May involve objects in the environment.

Self-Stimulation: verbal; repeated stereotyped utterances, may be words or sounds, which are not responsive to the environment.

Self-Abuse: head-banging, biting, scratching or pinching parts of his own body to an intensity that would seem to cause the child pain. Note: the child may not give evidence of feeling pain so coding of this behavior involves observer judgment.

Gross Physical Contact: "melting", clinging, leaning or draping of the child's body on the trainer.

Specific Physical Contact (SPC): physical contact with the trainer (pulling, moving the trainer's arm) which has a specific goal, i.e., reaching an object outside the child's range.

Aggression: pushing, hitting, biting, directed toward the trainer.

Eye-Contact: the child looks directly at the trainer's face, either on command or spontaneously. Code eye-contact by frequency. For eye-contacts of 5+ seconds, take duration.

Task-Orientation: (TO) this behavior has three requirements.

1. the child's eyes must be in contact with the materials he is using.
2. the child must be in physical contact with the materials.
3. his manipulation of the play materials must be appropriate to the preceding instruction or to the usually accepted way of using the objects.

Note: if any of these three requirements is missing, do not code.

Purposeful Play: same requirements as specified for Task Orientation, this category covers behaviors that the child emits spontaneously.

Object Contacts: A look, 5 seconds or more in duration or a physical contact with an object in the environment. Does not have to be appropriate.

Section Ia: _____

Child _____ Observer _____ Trainer _____

#/directions
#/right responses
%/right responses

Look at me.		
Look at the _____.		
Come here.		
Give me your hand.		
Sit down.		
Hands down (in lap).		
Touch your mouth.		
Touch your eye.		
Touch your ear.		
Touch my mouth.		
Touch my eye.		
Touch my ear.		
Get the blocks and bring them here.		
Bring me the toys.		
Put some beads . . .		
Other 1.		
2.		
3.		
4.		
5.		

Block building-Spontaneous

Highest #/blocks_____T.O._____Se

Imitative

#/blocks stacked

Trial 1____T.O.____sec.____

Trial 2____T.O.____sec.____

Trial 3____T.O.____sec.____

Puzzles

Total #/pieces____

#/pieces labeled O.K.____%____

#/pieces placed O.K.____%____

Stringing beads

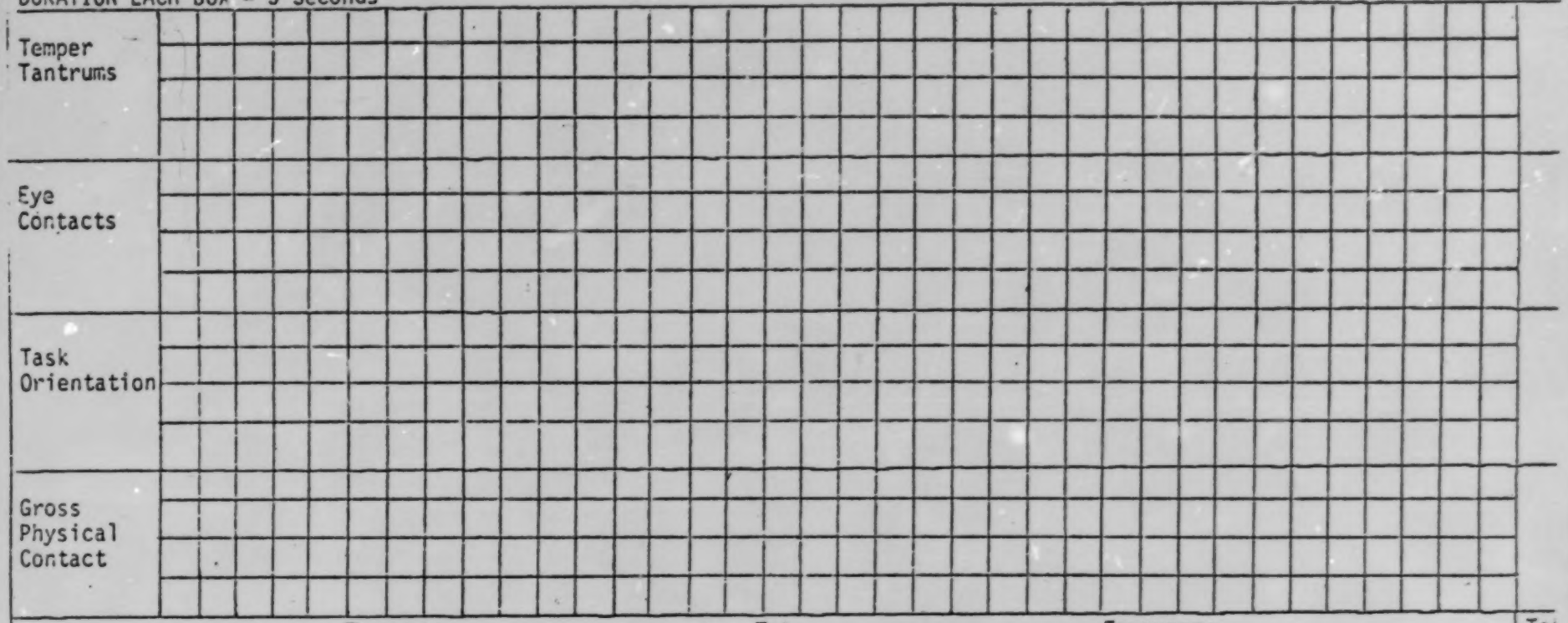
#·strung____T.O.____sec.____

Section Ib

Child | Observer | Trainer

DURATION EACH BOX = 5 Seconds

Tot.



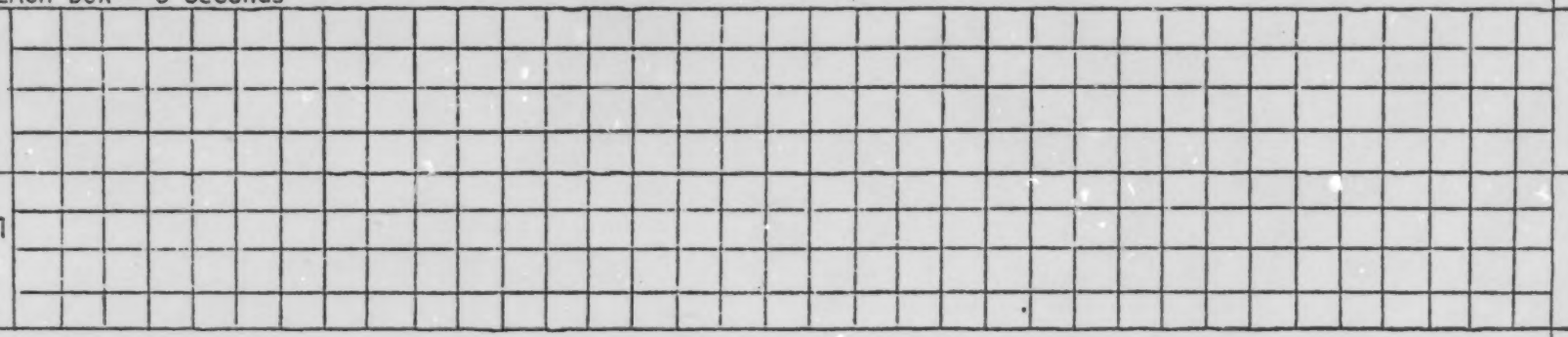
	Frequency	Tot.		Frequency	Tot.
words			Self-abuse		
phrases			1.		
sentences			2.		
echolalic			3.		
pronoun reversal			SPC		
calization			Aggression		
Physical			1.		
1.			2.		
2. 118			3.		
3.			Other		
Verbal					

119

Section II

Child | Observer | Tot. Sec.

DURATION EACH BOX = 5 Seconds



Frequency	Tot.	Frequency	Tot.
words		Self-Abuse	
phrases		1.	
sentences		2.	
echolalic		3.	
pronoun reversal		SPC	
ocalization		Aggression	
physical		1.	
1.		2.	
2.		3.	
3.		Other	
verbal		1.	
1.		2.	
2.		3.	
3.			
bj. Contacts			
1. ~~120~~			
2.			
3.			
4.			

121

Section IIIa: _____ Child _____ Observer _____ Trainer

#/directions
#/right responses
%/right responses

DURATION EACH BOX = 5 Seconds

Look at me.		
Look at the ____.		
Come here.		
Give me your hand.		
Sit down.		
Hands down (in lap).		
Touch your mouth.		
Touch your eye.		
Touch your ear.		
Touch my mouth.		
Touch my eye.		
Touch my ear.		
Get the blocks and		
bring them here.		
Bring me the toys.		
Put some beads . . .		
Other		
1.		
2.		
3.		
4.		
5.		

Block building-Spontaneous

Highest #/blocks____T.O.____

Imitative

#/blocks stacked

Trial 1____T.O.____sec.____

Trial 2____T.O.____sec.____

Trial 3____T.O.____sec.____

Puzzles

Total #/pieces____

#/pieces labeled O.K.____%____

#/pieces placed O.K.____%____

Stringing beads

strung____T.O.____sec.____

Form IIIb:

Observer | Trainer

Duration Each Box = 5 Seconds | Tot.5

Temper Tantrums

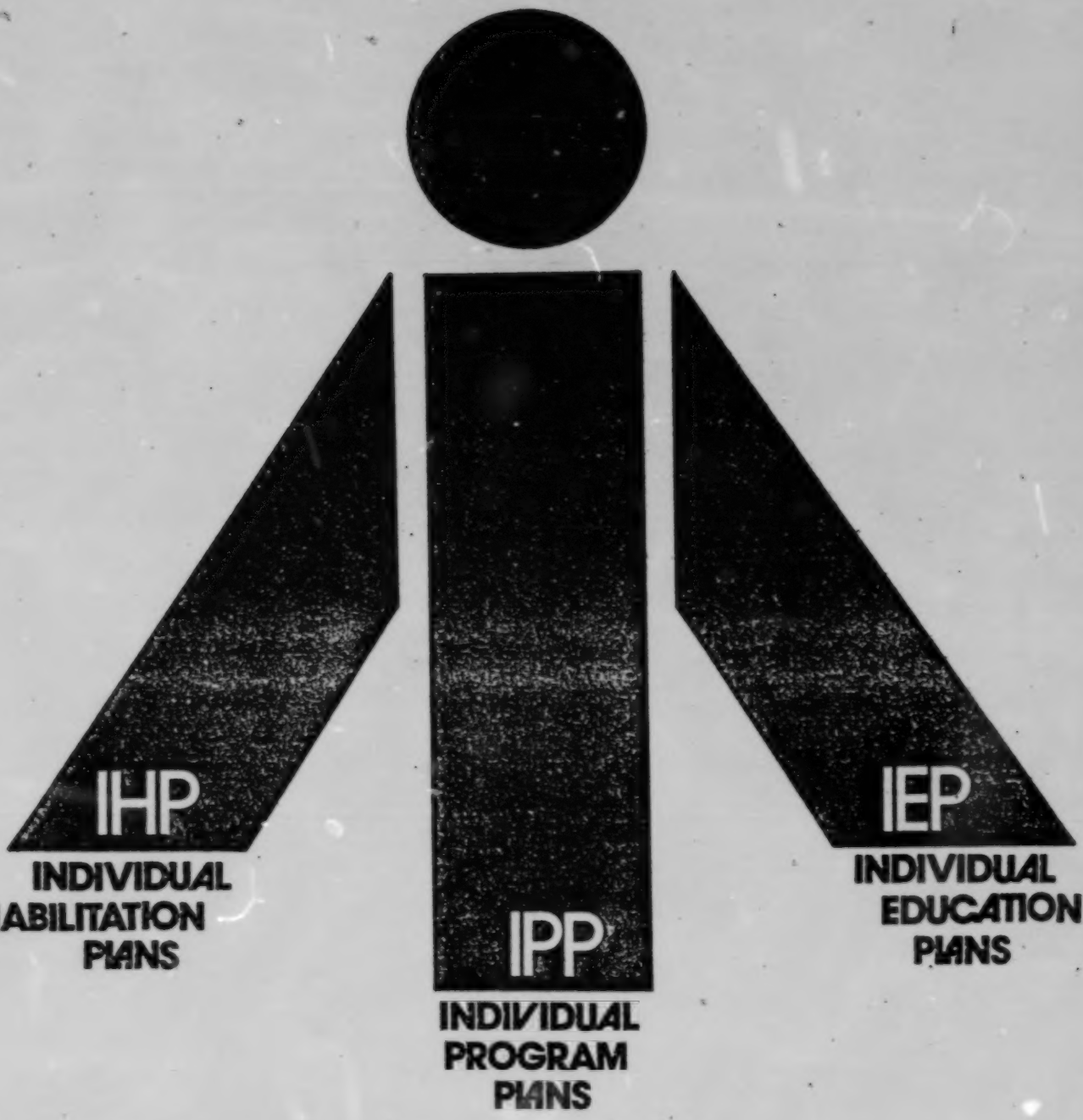
Eye Contacts

Task Orientation

Gross Physical Contact

37

Frequency	Tot.	Frequency	Tot.
		Self-abuse	
		1.	
		2.	
		3.	
		SPC	
		Aggression	
		1.	
124		2.	125
		3.	
		Other	



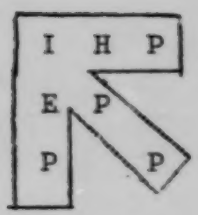
By
Alexander J. Tymchuk, Ph.D.
Annette Y. Dahlman, M.S.
Ivy M. Mooring, Ph.D.

dubnoff center
10526 Victory Place
North Hollywood, California 91606
(213)877-5678

INDIVIDUAL

EDUCATIONAL

PROGRAMS



by

Alexander J. Tymchuk, Ph.D.,[1] Annette Y. Dahlman, M.S.[2]
and Ivy M. Mooring, Ph.D.[3]

January, 1978

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1. Associate Professor, and Associate Director of the University Affiliated Facility for Training in Mental Retardation and, other Developmental Disabilities, Department of Psychiatry, University of California, Los Angeles.
Dr. Tymchuk's work is supported in part by Maternal and Child Health grant number 927.

2. Associate Executive Director, Dubnoff Center for Child Development and Educational Therapy, North Hollywood, California.

3. Executive Director, Dubnoff Center for Child Development and Educational Therapy and Assistant Director, Health Training Center, Department of Health, 11665 West Olympic Blvd., Los Angeles, California.

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I. INTRODUCTION

A. Rationale

There has been a clear recognition that individualized instructional plans are necessary to facilitate effective training of people with exceptional needs. This recognition derives from the fact that people with exceptional needs, whether children or adults, were not optimally served with group objectives and often taught in group situations. Special education programs are designed for children whose needs were not being met in regular education programs where training was often in a group setting rather than individually tailored and where objectives then were group objectives so that individual differences could not be responded to.

B. What's In a Name

There are a number of phrases that have been used to describe the concepts embodied in individual instructional plans. These phrases include, Individual Educational Plans (IEP), as outlined in the Federal and Public Law 94-142 and in states' educational plans; the Individual Habilitation Plan (IHP) as outlined in the Federal Rehabilitation Act; the Individual Program Plans (IPP) as outlined in some states' legislation and the Individual Development Plan (IDP) which also is used by some. However, whichever phrase is used, the intent and the requirements of each are similar.

C. Legislative Trends and Requirements

1. Public Law 94-142

In the appendix are the rules and regulations for the development of Individual Educational Plans as stipulated in P.L. 94-142 and as outlined in the Federal Register, Volume 42, Number 163, 23 August, 1977. The pertinent sections include 121a.340 through 121a.349.

The basic requirements include:

a) that each IEP be developed annually at the start of the school year.

b) that there be a multi-lateral process to the development of these IEP's which means that no one single person can determine what the IEP should be; rather appropriate representatives must decide.

c) that parents be involved in the decision-making process.

d) that the IEP include:

(i) the child's current performance level

(ii) long term (annual) goals

(iii) short-term objectives

(iv) the services to be provided

(v) initiation and completion dates

(vi) objective performance criteria and evaluation procedures

— that State or agency may use funds provided under Part B of the Act:

(a) To provide free appropriate public education to handicapped children who are not receiving any education and who are in the age groups not covered under § 121a.300 in that State; or

(b) To provide free appropriate public education to second priority children; or

(c) Both.

(20 U.S.C. 1411(b)(1)(B), (b)(2)(B), (c)(2)(A)(ii).)

§ 121a.324 Application of local educational agency to use funds for the second priority.

A local educational agency may use funds provided under Part B of the Act for second priority children, if it provides assurance satisfactory to the State educational agency in its application (or an amendment to its application):

(a) That all first priority children have a free appropriate public education available to them;

(b) That the local educational agency has a system for the identification, location, and evaluation of handicapped children, as described in its application; and

(c) That whenever a first priority child is identified, located, and evaluated, the local educational agency makes available a free appropriate public education to the child.

(20 U.S.C. 1411 (b)(1)(B), (c)(1)(B); 1414(a)(1)(C)(ii).)

INDIVIDUALIZED EDUCATION PROGRAMS

§ 121a.340 Definition.

As used in this part, the term "individualized education program" means a written statement for a handicapped child that is developed and implemented in accordance with §§ 121a.341–121a.349.

(20 U.S.C. 1401(19).)

§ 121a.341 State educational agency responsibility.

(a) *Public agencies.* The State educational agency shall insure that each public agency develops and implements an individualized education program for each of its handicapped children.

(b) *Private schools and facilities.* The State educational agency shall insure that an individualized education program is developed and implemented for each handicapped child who:

(1) Is placed in or referred to a private school or facility by a public agency; or

(2) Is enrolled in a parochial or other private school and receives special education or related services from a public agency.

(20 U.S.C. 1412 (4), (5); 1413(a)(4).)

Comment. This section applies to all public agencies, including other State agencies (e.g., departments of mental health and welfare), which provide special education to a handicapped child either directly, by contract or through other arrangements. Thus, if a State welfare agency contracts with a private school or facility to provide special education to a handicapped child, that agency would be responsible for insuring that an individualized education program is developed for the child.

§ 121a.342 When individualized education programs must be in effect.

(a) On October 1, 1977, and at the beginning of each school year thereafter, each public agency shall have in effect an individualized education program for every handicapped child who is receiving special education from that agency.

(b) An individualized education program must:

(1) Be in effect before special education and related services are provided to a child; and

(2) Be implemented as soon as possible following the meetings under § 121a.343.

(20 U.S.C. 1412 (2)(B), (4), (5); 1414(a)(5); Pub. L. 94-142, Sec. 8(c) (1975).)

Comment. Under paragraph (b)(2), it is expected that a handicapped child's individualized education program (IEP) will be implemented immediately following the meetings under § 121a.343. An exception to this would be (1) when the meetings occur during the summer or a vacation period, or (2) where there are circumstances which require a short delay (e.g., working out transportation arrangements). However, there can be no undue delay in providing special education and related services to the child.

§ 121a.343 Meetings.

(a) *General.* Each public agency is responsible for initiating and conducting meetings for the purpose of developing, reviewing, and revising a handicapped child's individualized education program.

(b) *Handicapped children currently served.* If the public agency has determined that a handicapped child will receive special education during school year 1977–1978, a meeting must be held early enough to insure that an individualized education program is developed by October 1, 1977.

(c) *Other handicapped children.* For a handicapped child who is not included under paragraph (b) of this action, a meeting must be held within thirty calendar days of a determination that the child needs special education and related services.

(d) *Review.* Each public agency shall initiate and conduct meetings to periodically review each child's individualized education program and if appropriate revise its provisions. A meeting must be held for this purpose at least once a year.

(20 U.S.C. 1412 (2)(B), (4), (5); 1414(a)(5).)

Comment. The dates on which agencies must have individualized education programs (IEPs) in effect are specified in § 121a.342 (October 1, 1977, and the beginning of each school year thereafter). However, except for new handicapped children (i.e., those evaluated and determined to need special education after October 1, 1977), the timing of meetings to develop, review, and revise IEPs is left to the discretion of each agency.

In order to have IEPs in effect by the dates in § 121a.342, agencies could hold meetings at the end of the school year or during the summer preceding those dates. In meeting the October 1, 1977 timeline, meetings could be conducted up through the October 1 date. Thereafter, meetings may be held any time throughout the year, as long as IEPs are in effect at the beginning of each school year.

The statute requires agencies to hold a meeting at least once each year in order to review, and if appropriate revise, each child's IEP. The timing of those meetings could be on the anniversary date of the last IEP meeting on the child, but this is left to the discretion of the agency.

§ 121a.344 Participants in meetings.

(a) *General.* The public agency shall insure that each meeting includes the following participants:

(1) A representative of the public agency, other than the child's teacher, who is qualified to provide, or supervise the provision of, special education.

(2) The child's teacher.

(3) One or both of the child's parents, subject to § 121a.345.

(4) The child, where appropriate.

(5) Other individuals at the discretion of the parent or agency.

(b) *Evaluation personnel.* For a handicapped child who has been evaluated for the first time, the public agency shall insure:

(1) That a member of the evaluation team participates in the meeting; or

(2) That the representative of the public agency, the child's teacher, or some other person is present at the meeting, who is knowledgeable about the evaluation procedures used with the child and is familiar with the results of the evaluation.

(20 U.S.C. 1401(19); 1412 (2)(B), (4), (5); 1414(a)(5).)

Comment. 1. In deciding which teacher will participate in meetings on a child's individualized education program, the agency may wish to consider the following possibilities:

(a) For a handicapped child who is receiving special education, the "teacher" could be the child's special education teacher. If the child's handicap is a speech impairment, the "teacher" could be the speech-language pathologist.

(b) For a handicapped child who is being considered for placement in special education, the "teacher" could be the child's regular teacher, or a teacher qualified to provide education in the type of program in which the child may be placed, or both.

(c) If the child is not in school or has more than one teacher, the agency may designate which teacher will participate in the meeting.

2. Either the teacher or the agency representative should be qualified in the area of the child's suspected disability.

3. For a child whose primary handicap is a speech impairment, the evaluation personnel participating under paragraph (b)(1) of this section would normally be the speech-language pathologist.

§ 121a.345 Parent participation.

(a) Each public agency shall take steps to insure that one or both of the parents of the handicapped child are present at each meeting or are afforded the opportunity to participate, including:

(1) Notifying parents of the meeting early enough to insure that they will have an opportunity to attend; and

(2) Scheduling the meeting at a mutually agreed on time and place.

(b) The notice under paragraph (a)(1) of this section must indicate the pur-

pose, time, and location of the meeting, and who will be in attendance.

(c) If neither parent can attend, the public agency shall use other methods to insure parent participation, including individual or conference telephone calls.

(d) A meeting may be conducted without a parent in attendance if the public agency is unable to convince the parents that they should attend. In this case the public agency must have a record of its attempts to arrange a mutually agreed on time and place such as:

(1) Detailed records of telephone calls made or attempted and the results of those calls.

(2) Copies of correspondence sent to the parents and any responses received, and

(3) Detailed records of visits made to the parent's home or place of employment and the results of those visits.

(e) The public agency shall take whatever action is necessary to insure that the parent understands the proceedings at a meeting, including arranging for an interpreter for parents who are deaf or whose native language is other than English.

(f) The public agency shall give the parent, on request, a copy of the individualized education program.

(20 U.S.C. 1401(19); 1412 (2)(B), (4), (6); 1414(a)(5).)

Comment. The notice in paragraph (a) could also inform parents that they may bring other people to the meeting. As indicated in paragraph (c), the procedure used to notify parents (whether oral or written or both) is left to the discretion of the agency, but the agency must keep a record of its efforts to contact parents.

§ 121a.346 Content of individualized education program.

The individualized education program for each child must include:

(a) A statement of the child's present levels of educational performance;

(b) A statement of annual goals, including short term instructional objectives;

(c) A statement of the specific special education and related services to be provided to the child, and the extent to which the child will be able to participate in regular educational programs;

(d) The projected dates for initiation of services and the anticipated duration of the services; and

(e) Appropriate objective criteria and evaluation procedures and schedules for determining, on at least an annual basis, whether the short term instructional objectives are being achieved.

(20 U.S.C. 1401(19); 1412 (2)(B), (4), (6), 1414(a)(5); Senate Report No. 94-168, p. 11 (1975).)

§ 121a.347 Private school placements.

(a) *Developing individualized education programs.* (1) Before a public agency places a handicapped child in, or refers a child to, a private school or facility, the agency shall initiate and conduct a meeting to develop an individualized education program for the child in accordance with § 121a.343.

(2) The agency shall insure that a representative of the private school facility attends the meeting. If the representative cannot attend, the agency shall use other methods to insure participation by the private school or facility, including individual or conference telephone calls.

(3) The public agency shall also develop an individualized educational program for each handicapped child who was placed in a private school or facility by the agency before the effective date of these regulations.

(b) *Reviewing and revising individualized education programs.* (1) After a handicapped child enters a private school or facility, any meetings to review and revise the child's individualized education program may be initiated and conducted by the private school or facility at the discretion of the public agency.

(2) If the private school or facility initiates and conducts these meetings, the public agency shall insure that the parents and an agency representative:

(i) Are involved in any decision about the child's individualized education program; and

(ii) Agree to any proposed changes in the program before those changes are implemented.

(c) *Responsibility.* Even if a private school or facility implements a child's individualized education program, responsibility for compliance with this part remains with the public agency and the State educational agency.

(20 U.S.C. 1413(a)(4)(B).)

§ 121a.348 Handicapped children in parochial or other private schools.

If a handicapped child is enrolled in a parochial or other private school and receives special education or related services from a public agency, the public agency shall:

(a) Initiate and conduct meetings to develop, review, and revise an individualized education program for the child, in accordance with § 121a.343; and

(b) Insure that a representative of the parochial or other private school attends each meeting. If the representative cannot attend, the agency shall use other methods to insure participation by the private school, including individual or conference telephone calls.

(20 U.S.C. 1413(a)(4)(A).)

§ 121a.349 Individualized education program—accountability.

Each public agency must provide special education and related services to a handicapped child in accordance with an individualized education program. However, Part B of the Act does not require that any agency, teacher, or other person be held accountable if a child does not achieve the growth projected in the annual goals and objectives.

(20 U.S.C. 1412(2)(B); 1414(a) (5), (6); Cong. Rec. at H 7152 (daily ed., July 21, 1975).)

Comment. This section is intended to relieve concerns that the individualized education program constitutes a guarantee by the public agency and the teacher that a child will progress at a specified rate. However, this section does not relieve agencies and teachers from making good faith efforts to assist the child in achieving the objectives and goals listed in the individualized education program. Further, the section does not limit a parent's right to complain and ask for revisions of the child's program, or to invoke due process procedures, if the parent feels that these efforts are not being made.

Direct Service by the State Educational Agency

§ 121a.360 Use of local educational agency allocation for direct services.

(a) A State educational agency may not distribute funds to a local educational agency, and shall use those funds to insure the provision of a free appropriate public education to handicapped children residing in the area served by the local educational agency, if the local educational agency, in any fiscal year:

(1) Is entitled to less than $7,500 for that fiscal year (beginning with fiscal year 1979);

(2) Does not submit an application that meets the requirements of §§ 121a.220–121a.240;

(3) Is unable or unwilling to establish and maintain programs of free appropriate public education;

(4) Is unable or unwilling to be consolidated with other local educational agencies in order to establish and maintain those programs; or

(5) Has one or more handicapped children who can best be served by a regional or State center designed to meet the needs of those children.

(b) In meeting the requirements of paragraph (a) of this section, the State educational agency may provide special education and related services directly, by contract, or through other arrangements.

(c) The excess cost requirements under §§ 121a.182–121a.186 do not apply to the State educational agency.

(20 U.S.C. 1411(c)(4); 1413(b); 1414(d).)

Comment. Section 121a.360 is a combination of three provisions in the statute (Sections 611(c)(4), 613(b), and 614(d)). This section focuses mainly on the State's administration and use of local entitlements under Part B.

The State educational agency, as a recipient of Part B funds is responsible for insuring that all public agencies in the State comply with the provisions of the Act, regardless of whether they receive Part B funds. If a local educational agency elects not to apply for its Part B entitlement, the State would be required to use those funds to insure that a free appropriate public education (FAPE) is made available to children residing in the area served by that local agency. However, if the local entitlement is not sufficient for this purpose, additional State or local funds would have to be expended in order to insure that "FAPE" and the other requirements of the Act are met.

Moreover, if the local educational agency is the recipient of any other Federal funds, it would have to be in compliance with Subpart D of the regulations for section 504 of the Rehabilitation Act of 1973 (45 CFR Part 84). It should be noted that the term "FAPE" has different meanings under Part B and section 504. For example, under Part

2. State Education Plans: California's Master Plan for Special Education

Most state departments of education have developed their own legislation to implement the requirements of P.L. 94-142 and many states have gone further than the legislative intent since they had developed similar programs before the advent of 94-142.

In California, the California Administrative Code, Title 5, Regulations 1, Article 4, Section 3154 of 22 May, 1977, contains the requirements for IEP's. These requirements are similar to those of P.L. 94-142, but have some additions. These additions include:

a) that the IEP's should be in the areas of
   academic achievement
   social adaptation
   prevocational and vocational skills
   psychomotor skills
   self-help skills

b) that the IEP's should include any special instructional media and materials needed;

c) that the IEP's should indicate what type of special physical education program is used if needed;

d) that the IEP's indicate who would be responsible for implementing the program.

The full text of these regulations are in the Appendix.

CALIFORNIA ADMINISTRATIVE CODE
TITLE 5, REGULATIONS
ARTICLE 4, SECTION 3154
22 May, 1977

DO NOT WRITE IN THIS SPACE

3154. Individualized Education Program. (a) Each local education agency shall develop or revise, whichever is appropriate, an individualized education program for every individual with exceptional needs, effective for use at the beginning of each school year. This written individualized education program shall be developed by the assessment team for each individual with exceptional needs upon the determination of eligibility for special education and related services. It shall be implemented by those professional persons specified in the written individualized program, pursuant to provisions of Section 3154(b)(7). The individualized education program shall be reviewed periodically, but not less than annually, for each pupil who receives special education and related services. The persons who shall develop or revise the individualized education program shall include, but need not be limited to, a special education administrator or designee; the pupil's special or regular teacher(s); the pupil's parent(s); and when [redacted] appropriate, the pupil; and other competent persons, as may be appro[redacted]e, who are knowledgeable concerning the special educational needs of such pupil; and members of an admission committee if required by the Education Code.

(b) The written individualized education program for a pupil shall

include, but need not be limited to statements of:

(1) The pupil's present levels of educational performance, including academic achievement, social adaptation, prevocational and vocational skills, psychomotor skills, and self-help skills.

(2) The long-range goals and periodic objectives shall be stated in terms of pupil performance; shall be time-referenced and state the method of measurement(s) or other data to be used to determine whether or not anticipated levels of attainment have been reached; and shall project a date of accomplishment for each of these objectives.

The professional staff persons responsible for implementing the individualized education program shall develop and implement written short-term objectives for specific instructional areas. A member of the assessment team who developed that individualized education program shall consult with the staff in developing and implementing these objectives; and these written short-term objectives shall become a part of the written individualized program.

(3) The specific educational services clearly demonstrated to be needed by the individual (without regard to the availability of those services), including a description of:

(A) All special education and related services which are needed to meet the unique needs of that pupil.

(B) Any special instructional media and materials which are needed.

(C) Type of special physical education program if needed by the pupil.

(D) The career and vocational education program in which the pupil may participate.

DO NOT WRITE IN THIS SPACE

(E) Anticipated timeline for provision of any service not immediately available to that pupil.

(4) A description of the extent to which the pupil will participate in regular education programs.

(5) The projected date of placement of the pupil in the special education program and related services, and the projected duration thereof.

(6) A rationale for the type of educational placement which the pupil will have in keeping with the least restrictive educational environment concept.

(7) A list of the individuals who are responsible for implementation of the individualized education program at the time the plan is initiated.

(8) The objective criteria, evaluation procedures, and schedules for determining, at least annually, whether the instructional objectives are being achieved.

(9) The individualized education program is a statement of the services to be delivered and of the anticipated goals and objectives for the pupil; but is not a contract which guarantees the accomplishment of the anticipated goals and objectives.

DO NOT WRITE IN THIS SPACE

3. State Health Plans: California

In addition to the State Department of Education plans for IEP's, most State Departments of Health have legislation for Individual Program Plans (IPP's) for individuals who may be served in the health field. The basic requirements for IPP's are much the same as those for IEP's. The full text of Assembly Bill 3804, Chapter 1368 for California is in the Appendix,

D. Difficulties With the Legislative Guidelines

Although the intent of the various pieces of legislation is understood, the legislation is not specific as to how the IPP's or IEP's are to be developed and the process implemented. Consequently, there may be vast differences between agencies and states in these processes and particularly in format.

Another difficulty with the legislation relates to the general lack of specificity to curriculum or content areas in which the IEP's or IPP's should be developed. To be maximally effective, the IEP's should be part of a curriculum package that allows for determination of the next step for the individual.

E. The Approach Taken Here

The approach taken by the authors was developed, utilized and refined with teachers in public and private schools who worked in regular or special classes.

a regional center contract with another governing board. In no event shall the department directly operate a regional center program for longer than 120 days before contracting with a new governing board. The department may, if requested by the new governing board, continue to provide additional assistance to avoid disruption of the service program, until such time as the governing board has assumed full responsibility for the operation of the program.

Article 2. Regional Center Responsibilities

38209. Contracts between the department and regional centers shall specify the service area and the categories of persons that regional centers shall be expected to serve and the services to be provided. In order to assure uniformity in the application of the definition of developmental disability contained in this division, the Director of Health shall, by March 1, 1977, issue regulations that delineate, by diagnostic category and degree of handicap, those persons who are eligible for service by regional centers. In issuing the regulations, the director shall invite and consider the views of regional center contracting agencies, the state council, and persons with a demonstrated and direct interest in developmental disabilities.

38210. All regional centers shall conduct case-finding activities, including notification of availability of service in English and such other languages as may be appropriate to the service area, outreach services in areas with a high incidence of developmental disabilities, and identification of persons who may need service.

38211. Any person believed to have a developmental disability, and any person believed to be a high risk of parenting a disabled infant, shall be eligible for initial intake and assessment services in the regional centers.

Initial intake shall be performed within 15 working days following request for assistance. Initial intake shall include, but need not be limited to, information and advice about the nature and availability of services provided by the regional center and by other agencies in the community, including guardianship, income maintenance, mental health, housing, education, work activity and vocational training, medical, dental, recreational, and other services or programs that may be useful to persons with developmental disabilities or their families. Intake shall also include a decision to provide assessment.

38212. If assessment is needed, it shall be performed within 60 days following initial intake. Assessment may include collection and review of available historical diagnostic data, provision or procurement of necessary tests and evaluations, and summarization of developmental levels and service needs. If unusual circumstances prevent the completion of assessment within 60 days following intake, such assessment period may be extended by one 30-day period with the advance written approval of the department.

38213. In addition to any person eligible for initial intake and assessment services, regional centers may provide or cause to be provided preventive services to any potential parent determined to be at high risk of parenting a disabled infant.

38214. If any person requests regional center services and is found to be ineligible for such services, the reasons for denial shall be presented in writing to the applicant and, if necessary, a referral to other appropriate services shall be arranged. In such cases, the applicant shall also be advised in writing of the appeals procedure established in this division.

38215. On and after January 1, 1977, an individual program plan may be developed for any person who, following intake and assessment, is found to be eligible for, and in need of, such plan. Such plans shall be completed within 60 days of the completion of assessment.

Individual program plans shall be prepared jointly by one or more representatives of the regional center, the developmentally disabled person, and where appropriate, the person's parents, legal guardian or conservator.

The program plan shall include the following:

(a) An assessment of the developmentally disabled person's specific capabilities and problems. The regional centers, in cooperation with the department, shall adopt an approved list of tests to be used by all regional centers in making such assessments. The test or tests used shall have been determined to be reliable and valid by acceptable statistical methods.

(b) A statement of specific, time-limited objectives for improving the capabilities and resolving the problems of the person. Such objectives shall be stated in measurable terms which allow measurement of progress.

(c) A schedule of the type and amount of services to achieve program plan objectives, including identification of the provider or providers of service responsible for attaining each objective.

(d) A schedule of regular periodic review and reassessment to ascertain that planned services have been provided and that objectives have been reached within the times specified. The same test or tests used to measure client capabilities and problems shall be used for review and reassessment.

(e) All individual program plans shall be reviewed and modified if necessary, at least annually by the regional center representative and the person, the person's parents, legal guardian, or conservator.

The state department, with the participation of regional center personnel, shall prepare a standard format for the preparation of individual program plans, which shall be used by all regional centers.

38215.1. By January 1, 1979, all active cases shall have an individual program plan as specified in Section 38215.

38216. In order to achieve the stated objectives of any individu

program plan, the regional center shall conduct activities including, but not limited to, the following:

(a) Program coordination which may include securing, through purchase or referral, services specified in the person's plan, coordination of service programs, information collection and dissemination, and measurement of progress toward objectives contained in the person's plan.

The regional center shall assign a program coordinator who will be responsible for implementing, overseeing, and monitoring each individual program plan. The program coordinator may be an employee of the regional center or may be a qualified individual or employee of an agency with whom the regional center has contracted to provide program coordination.

At such times as the individual program plan is reviewed, but at least annually, the performance of the program coordinator shall also be reviewed by the regional center, the person with developmental disabilities, and the person's parents or legal guardian or conservator. No person shall continue to serve as a program coordinator for any individual program plan unless there is agreement by all parties that the person should continue to serve as program coordinator.

Nothing shall prevent a person with developmental disabilities or such person's parent, legal guardian, or conservator, from being the program coordinator of the person's individual program plan, if the regional center director agrees that such an arrangement is feasible and in the best interest of the person with the developmental disabilities. If any person listed above is designated as the program coordinator, such person shall not deviate from the agreed-upon program plan and shall provide any information and reports as may be required by the regional center director.

(b) Purchase of needed services.

A regional center may purchase services for a client from any individual or agency the regional center determines will best accomplish all or any part of that client's program plan.

In making the initial choice to purchase services from an agency, facility, or individual, the regional center may use a professionally recognized, reliable, and valid instrument of accreditation. Thereafter, the regional center shall renew its contracts or purchases on the basis of a vendor's success in achieving the objectives set forth in the individual program plan.

No purchase of service contract with any agency or individual shall be continued unless the regional center and the person with developmental disabilities, or when appropriate, the person's parents or legal guardian or conservator agree that reasonable progress has been made towards the objectives for which the service provider is responsible.

Regional center funds shall not be used to supplant the budget of any agency which has a legal responsibility to serve all members of the general public and is receiving public funds for providing such services.

A regional center may purchase required out-of-home care for developmentally disabled persons. In considering appropriate placement alternatives for developmentally disabled children, approval by the child's parent, guardian, or conservator shall be obtained before placement is made.

Each developmentally disabled person placed by the regional center in an out-of-home residential facility shall have the rights specified in this division. These rights shall be brought to the person's attention by such means as the Director of Health may designate by regulation.

(c) Advocacy for, and protection of, the civil, legal, and service rights of developmentally disabled persons as established in this division.

Whenever the advocacy efforts of a regional center to secure or protect the legal, civil, or service rights of any of its clients prove ineffective, the regional center or the person with developmental disabilities or their parents, legal guardian, or other representative may request the area board to initiate action under the provisions defining area board advocacy functions established in this division.

(d) Community organization and program development, including liaison activities with existing service agencies, identification of services needed but unavailable, identification of ineffective services and services of poor quality, identification of programs which may not be in compliance with local, state, and federal statutes and approved regulations.

In order to expand the availability of needed services of good quality, a regional center may take any of the following actions:

(1) Provide information to the area board to assist the area board in determining recommended priorities for program development for inclusion in the state plan.

(2) Request the department to allocate funds from the Developmental Disabilities Program Development Fund to initiate a new program.

(3) Notify the appropriate licensing authority or request the area board to investigate and act upon any agency's possible noncompliance with local, state, or federal laws or regulations.

(4) Provide or secure consultation, training, or technical assistance services for any agency to assist such agency in upgrading the quality of its program. Except in emergency situations, a regional center shall not provide direct treatment and therapeutic services, but shall utilize appropriate public and private community agencies and service providers to obtain such services for its clients.

38217. Regional centers shall cooperate with area boards in joint efforts to inform the public of services available to persons with developmental disabilities and of their unmet needs, provide materials, and education programs to community groups and agencies with interest in, or responsibility for, persons with

II. REASONS FOR IPP's

There are several reasons for the development of IPP's. First, there are the legislative mandates as outlined in the previous section. Second, IPP's that fulfill all requirements allow for the direct comparison across programs and techniques. In additon, IPP's allow for ease of communication.

III. CHARACTERISTICS OF IPP's

A. Individualized Goals and Objectives

As the name implies, the IPP contains the goals for a single individual and not those for a group. In addition, the IPP should contain both short-term objectives and long-term goals. The objectives refer to those behaviors that the child will be expected to achieve within about a month. The goals are those behaviors that the child is expected to achieve by the end of the year.

Both the short-term objectives and long-term goals are determined by evaluation of the child's abilities as well as by the rate at which the child achieved previous skills.

B. Specific Goals

The IPP's should contain specific goals rather than general goals and should be specific to each content area. Thus, an IEP could be stated that there will be improvement in Social Adaptation. This goal is too general. A more specific goal would be that the child will be able to tie his/her shoelace. Similarly, in the Sensorimotor area, a general statement would be the child would show improvement in walking. Again, however, a more specific statement would be that the child would be able to take five steps unassisted.

B. Specific Goals (continued)

IPP's should be developed in each of the content areas including:

Social adaptation including self-help skills

Sensorimotor

Cognitive

Communication

Affective

Although the present authors see these five content areas as including most areas in which IPP's would be developed, others might consider removing such areas as Safety or Vocational Skills as separate areas rather than as extensions of the Social or Cognitive areas.

C. Observable Goals

Related to the need for specificity of goals, is the need that these goals be observable, that is, that the goals be stated in such a way so as anyone reading the goals can readily determine what it is. Operationalizing the goal insures observability.

For example, improvement in Social Adaptation is not observable in and of itself until Social Adaptation is defined. "Tying his/her shoelace" is one part of Social Adaptation and is observable.

Another example, is that "there will be improvement in self-concept." Self-concept is a construct, a fiction, a term that refers to other behaviors. Since self-concept is a construct it cannot be observed until it is determined which behaviors the term refers to. One behavior that could be seen under self-concept is how often a person says "How do you do?"

D. Replicable Goals

If several people were asked what intelligence was, there would be several different answers. If several people were asked what self-concept was, there would be several different answers. Since both intelligence and self-concept do not have referents in real life, they are not observable and as a result, individual people can place whatever definitions they like on each term. Thus, where one teacher may say that a girl's intelligence will improve as a result of an intervention and by this, the teacher means (but does not specify) that the girl will be able to speak better. Another teacher or parent may read the IEP and consider intelligence to mean learning to explore. The goal of improvement in intelligence is not replicable because it is neither observable nor specific.

A measure of replicability that is sometimes used is inter-observer reliability. Reliability refers to the extent of agreement there is between two or more people. Perfect reliabilit is represented by 1 or 100% while 0 means that there was complete disagreement, and .5 or 50% means that there was agreement half the time or on half the items.

In the above example on intelligence, there was complete disagreement; however, if both teachers agreed that intelligence meant speaking better then there would be complete agreement or reliability. A problem still exists, however, since "speaking better" is too general and there may be disagreement later. For one teacher, "speaking better" = saying the words "come here", whereas for the other teacher, "speaking better" = saying all words in a louder tone of voice.

E. Measurable Goals

One of the critical aspects of legislation related to the IEP, IHP, or IPP is that the goals and objectives must be measurable so that progress or deterioration or stability can be determined.

Measurement can be of two kinds; standardized or nonstandardized.

1. Standardized Measurement

Standardized measurement refers to the use of measurement (or assessment or evaluation) tools that have rigorous criteria for their development. Usually such criteria include reliability, validity, and norm characteristics.

a) Reliability

Reliability refers to whether the test, if taken twice by the same child under similar conditions without a great time span between testings, will provide a similar score both times. Reliability of an instrument is again shown in terms of 1 or 100% with both indicating total reliability. For example, if a child scored 100 on the Wechsler Intelligence Scale for Children - Revised (WISC-R) and a week later, took the test again and got 100, the reliability would be excellent. If, on the other hand, the child received a score of 90 the second time, reliability would be .9 or 90%.

b) Validity

Validity refers to how well the instrument measures what it was designed to measure. This is content

E. Measurable Goals - Validity (continued)

validity and is a more powerful form of validity than face validity. Face validity refers to the fact that the test appears to be measuring what it is supposed to. If a test was designed to measure reading comprehension, then one way in which to determine whether it has face validity, is to take it. If it has face validity, then to determine if it has content validity is to correlate the scores obtained by children on that test with scores taken on another test of reading comprehension. If the scores are equal or similar, then the correlations are high and the first test is considered to be valid.

c) Norm Characteristics

When a test is standardized, it is first given to representative samples of people where the test will be given in the future so that the individual's score can be compared with that sample. Usually, samples (or norms or normative data), are selected at random from the age range in which the test is to be used and will include random samples from the male and female population, according to geography, locale (urban - rural), socioeconomic status, race or ethnic group, and occupation. A child will be given the test then when she/he comes from the group or groups on which the test was standardized.

E. Measurable Goals (continued)

d) Types of Standardized Measurement Instruments

There are numerous standardized measurement instruments for children and adults and are administered by trained personnel so as to give a valid score. The general areas in which these tools fall are educational and psychological. Educational tests are sometimes given by teachers, but most often are given by educational specialists trained for this purpose as well as to translate the results into educational program information. Educational tests include these for general academic subjects as well as those that measure more specific abilities. The Illinois Test of Psycho-linguistic Abilities (ITPA), for example, provides information on visual and auditory perception and discrimination.

Psychological tests are to be given only by trained psychologists or psychometrists under the supervision of a psychologist.

Psychological tests include intelligence tests, personality tests, vocational tests, as well as tests that are developed for specific psychological purposes. Some of these tests include tests of fine or gross motor ability, of tactile ability, of auditory or visual perception or discrimination. There are other tests that are more specialized and are generally

E. Measurable Goals - Types of Standardized Measurement Instruments (continued)

considered to be tasks rather than tests, but they can be used as a test and include verbal mediational tasks, memory tasks, and reaction time tasks.

e) How to Select a Suitable Standardized Measurement Instrument

Selection of a standardized measurement instrument should be dictated by the behavior to be measured. If intelligence is to be measured, then a test of intelligence should be selected. If reading comprehensic is to be measured, then a test measuring reading comprehension would be used.

It is difficult to be informed about all tests so that the individual teacher or counselor should consult with an educational specialist or psychologist as to possible tests as well as their suitability for a particular child. Such information then can be reliably translated to the parents.

2. Nonstandardized Measurement

Nonstandardized measurement refers to measurement tools that do not meet the criteria of standardized tools listed above. Such tools include questionnaires used to sample public opinion or to gather historical data about a family or a child.

The fact that these tools are not standardized, however, does not make them any less valuable than standardized tools. Nonstandardized tools are very valuable in developing individual plans. Originally, most standardized tools, and

2. Nonstandardized Measurement (continued)

particularly intelligence tests, were developed as a systematic way to make comparisons between groups or between individuals within groups. Unfortunately, these tests did not allow for individuals who may not fit within these groups and hence, are not appropriate for use with them. Individuals, who had abilities that were not yet at the levels assessed by these tools, then could not be reliably assessed by using those tools. Such individuals included some of the mentally retarded as well as those with behavioral or physical handicaps.

A person with a right hemiplegia where the right hand is paralyzed cannot be expected to write as well as another person without that paralysis if that is their dominant hand. To then make comparisons on a test of writing between these two people is unfair and inappropriate. The person with the right hemiplegia should be compared to him or herself or to others with right hemiplegis if it is absolutely necessary to make comparisons.

Although the term nonstandardized is used to refer to measurement tools that do not meet the requirements of standardization, the forms have conditions that must be fulfilled if they are to be anyway useful. These conditions include specificity, observability, replicability, and measurability. How to fulfill these conditions will be discussed in the next section on developing an Individualized Program Plan.

2. Nonstandardized Measurement (continued)

For now, it is important to remember that the most important trait of an IPP is that of measurability so that progress towards the attainment or completion of that plan can be determined. In order to be measurable, however, the IPP must meet the other traits outlined above including being specific, observable, and replicable. As an example, if the IPP was to improve intelligence, a standardized test of intelligence could be used to measure progress; however, an IPP that states to improve intelligence does not meet the criteria of being specific, observable and replicable. Thus, a more specific goal may be to have the child read a short story and a standardized test of reading ability may be used to measure progress and attainment.

F. Evaluation of Goals

The last requirement of the individual plans is that of evaluation. Measurement and evaluation often are seen as being synonymous, but in this case, they are different. Where measurement refers to the type of method of determining how well a person performs, evaluation refers to the process involved in that determination. Evaluation of IPP's should be done at least annually; however, it can be done more often and may need to be done so.

IV. A FORMAT FOR IEP/IPPs

Form G contains one format for the presentation of the IPP (or IEP or IHP). One of these forms should be used for each program or curriculum area. Several objectives in each program or curriculum area can be placed on each sheet with additional sheets being used if necessary.

A. Headings

At the top of the form, there are a number of headings. These headings are designed to facilitate the development of the IPP's. The title "Individual Program Plans" can be changed to "Individual Educational Plan" or "Individual Habilitation Plan" depending upon the need.

B. Clients' Name/Signature

The clients' name should be placed here as well as his/her signature and the date when s/he signed. The determination of those who sign and consent to their program has not yet been clarified; however, the legal age for informed consent is one guideline.

C. Program Area

The program or curriculum area refers to the area in which the IPP's is being developed. These areas may differ, but generally would include the social adaptation, sensori-motor, cognitive, communication and affective areas.

D. Parents' (Guardian, Advocate) Signature/Date

The parents or guardian should participate in the process of developing the IPP at some point and should be informed of the different aspects of the plan. The parent or guardian should then sign the IPP signifying

Individual Program Plans (IPP)

Client's Name/Signature:_____ Date of Meeting:_____ Date Started:_____

Program Area:_____ Those Attending:_____ Date Completed:_____

Parent's (Guardian,Advocate) Teacher/Trainer:_____
Signature/Date:_____

Objective	Teaching Strategies	
I.P.O.		Materials
		Evaluation Criteria
		Evaluation Procedures
		Baseline

that they understand and accept the IPP.

In some instances where an advocate is used, that person may sign as well.

E. Date of Meeting

The date of the meeting when the IPP is developed and when the client and/or parent signs it should be placed here. If there were several meetings, only the date of the last meeting, when the IPP was signed, should be recorded on the IPP form.

F. Those Attending

The process of the development of the IPP should be interdisciplinary, whereby all of the client's needs are determined and the treatment goals and treatment methods decided upon. The names of those attending the meeting where the IPP is developed and finalized should be recorded.

G. Date Started

The date when the training for the IPP begins should be inserted here.

H. Date Completed

The date when the IPP has been completed should be inserted here.

I. Teacher Trainer

The name of the person or persons responsible for implementing the IPP should be inserted here.

J. Objective

The objective column refers to the specific long-term goals and short-term objectives within each programmatic

or curriculum area. A useful guide is to provide the long-term goal with a superordinate number and the short-term objective with a subordinate number. For example, it may be useful to designate the five curriculum areas as

1. social adaptation
2. sensorimotor
3. cognitive
4. communication
5. affective

Then sub-areas would be designated as

1. social adaptation
   - 1.1 self-help
     - 1.1.1 feeding
     - 1.1.2 dressing
   - 1.2 safety
     - 1.2.1 transportation
     - 1.2.2 pedestrian

Another way to designate is

I. Social Adaptation
   - A. Self-help
     - 1. Feeding
       - a. uses ford
         - i. reaches for fork
         - ii. closes fingers on fork stem
         - iii. lifts fork
         - iv. inserts fork in (potatoes)
         - v. lifts fork to mouth

vi. removes fork

vii. places fork on plate (or takes another sample)

b. uses spoon for stirring

With either of these designations in mind, the objective is written:

I. Will show good Social Adaptation

A. in the self-help area

1. by feeding self

a. using the fork

Depending upon the person's capabilities, even "a. using the fork" could be broken down into its components. Thus, the expectation is that the objective of "using the fork" will be completed and in so being completed, will be leading to good social adaptation.

K. Teaching Strategies

The teaching strategies refer to how the objectives will be accomplished. Although there is not a legislative mandate for a specific type of teaching or training strategy to be used, there is for describing how the objectives are to be accomplished. This description can be a general one; however, in order for the parents and others to understand and to accept the IPP, being more specific makes such understanding easier. In addition, when there may be a particular training approach to be used, the approach should be described beforehand. For example, for some, the systematic use of reinforcement (perhaps using food), may be objected to. A clarification that this was being done

before the program begins would prevent difficulties later. Another example is that, for some, the use of a punisher, either in the form of a "No!" or in the form of sitting in the corner, may be objected to. Again, clarification is needed to ensure that the parents are informed and agree.

Finally, it is advantageous to specify the teaching or training strategies so that there is consistency in working with the client. The teacher or trainer, the aide, or the parent can see specifically what is being taught and can be consistent. If a client moves to another class, the specific plan can be used there as well. And the teacher gradually can build a library of strategies to be used with others.

L. Materials

All of the materials to be used in accomplishing the objectives should be listed. These materials may include a special reading book or blocks.

M. Evaluation Criteria

The evaluation criteria refer to the levels of success that will be accepted as showing that the client is able to perform the particular objective. These evaluation criteria are tied directly to the assessment tool that is selected. The assessment tool can be either a standardized or non-standardized instrument. For example, if the curriculum area is Reading and the client is learning to read short paragraphs, there may be a test to measure the client's ability in reading, such as the Wide Range Achievement

Test (WRAT), that could be used to assess success. Or if the curriculum area is Arithmetic, the WRAT could be used as well or a similar non-standardized test also can be used; for example, in Arithmetic, a teacher-made test of 10 items selected to be representative of the skill taught, could be used. The evaluation criteria then might read:

> "Will complete teacher-made test of ten items with at least 8 correct."

If time or speed in doing the task was important, it might read:

> "Will complete teacher-made test of ten items with at least 8 correct in 10 minutes."

There are other non-standardized ways of assessing behavior as well. The main method is through observation, which is particularly useful when there are not any standardized tests available to evaluate the particular behavior or where teacher-made tests cannot be used.

Up to the present, there have been few standardized evaluation instruments that could be used with people with exceptional needs. Alternative instruments including the Allpern-Boll, the Vineland Social Maturity Scale or the American Association on Mental Deficiency's Adaptive Behavior Scale have been developed to help assess social adaptation and are standardized so that there is an opportunity to make comparisons across groups. In addition to these tools, several non-standardized ones have been developed including the CCEM and PAC. Both the CCEM and

the PAC provide objectives that can be used for the IPP's; unfortunately, for assessment, both only provide for a yes/no response that the objective has been met. Another difficulty with each is that the objectives are not broken down into small enough components. However, both can be used where another instrument does not exist for observation purposes.

There are three types of data that can be used for evaluation when observation is used:

1. Frequency (F)

   The first type of data is frequency, whereby, the number of times a particular behavior occurs is counted. For example, if the objective is to have a child request permission to leave the room without prompting, the number of times s/he does so would be recorded. Or if the objective is to have the child follow commands, the number of times s/he responds to the command would be recorded.

2. Rate (R)

   The second type of data is rate which is an expression of the number of times something occurs per unit of time. Most often frequency data should be expressed as a rate to be accurate. The concept of rate is an important one and can lead to misleading data if not understood. For example, if a child asks permission twice one day and three times the next day, does this mean that s/he has improved? S/he has improved if the time in class was the same

for both days. If, however, on the first day, s/he was in class for one hour and for two hours on the second, this means that s/he asked permission a rate of once an hour on the first day, but only .66 times an hour the second. The latter figure means that the child has actually deteriorated and not improved.

Rate is calculated by dividing the length of time observed by the frequency of the behavior. For example, a boy is asked by his teacher to follow five commands in five minutes and he follows four. The rate = $\frac{4}{5}$ = .80 or that he followed the commands 80% of the time.

3. Duration (D)

The third type of data is duration, which is a statement of the length of time that a behavior occurs, whereas, frequency and rate are used to assess an event that may occur over time. Those objectives that might require a duration measure include how long a child remains at his seat, how long a child plays with another child without screaming, how long a man works at a task in a workshop, how long a child maintains eye contact with the teacher. Seconds, minutes or hours are used to measure duration. Occasionally, both types of data may be needed for the same IEP. For example, if the objective for a boy who yells all the time in class is to have him sit and work quietly,

the assessment measure may be using frequency data to determine how many times he yells; however, it would be important to know how long he yells as well. On the first day the documentation of his behavior looked like this:

	Frequency	Duration	Time on Task (between yells)
DAY 1	1	15 minutes	1 minute
	2	10 minutes	5 minutes
	3	8 minutes	6 minutes
	4	5 minutes	10 minutes
TOTALS	4	38 minutes	22 minutes

These data show that for an hour period, this boy yelled 4 times for a total time of 38 minutes, but the duration of each yell decreased from 15 minutes to 5 minutes. On subsequent days, after training began, his data looked like this:

	Frequency	Duration	Time on Task
DAY 2	1	9 minutes	5 minutes
	2	7 minutes	9 minutes
	3	5 minutes	10 minutes
	4	4 minutes	11 minutes
TOTALS	4	25 minutes	35 minutes

		Frequency	Duration	Time on Task
DAY 3		1	7 minutes	7 minutes
		2	5 minutes	9 minutes
		3	3 minutes	13 minutes
		4	2 minutes	14 minutes
	TOTALS	4	17 minutes	43 minutes

		Frequency	Duration	Time on Task
DAY 4		1	2 minutes	9 minutes
		2	1 minute	11 minutes
		3	25 seconds	15 minutes
		4	20 seconds	21 minutes, 15 seconds
	TOTALS	4	3 minutes, 45 seconds	56 minutes, 15 seconds

These data demonstrate that if only a frequency measure was used, there would not be any improvement over the 4 days since he still yells 4 times each hour. Duration of the yelling and time on task, however, show an inverse relationship. The duration of the yells decrease while time on task increases, showing that there is improvement. Duration of the yells decrease from 38 minutes to only 3 minutes, 45 seconds on the fourth day.

In this actual case from the senior author's work, there is another factor that must be considered and that is the change in the quality of the behavior. Whereas, frequency and duration are quantitative measures and show that this boy's

yelling decreased, there are also qualitative differences. Although it is difficult to describe the qualitative changes on paper, his yelling at the start was very loud. At the end, his yelling was soft. This means that in reality the definition of yelling had changed over time and should be taken into account in demonstrating that improvement has occurred.

There is another way to demonstrate change and that is to video- or audio-tape the child. Portions of these tapes then can be stored to supplement the other assessment procedures.

In summary, there are several ways to evaluate the clients' abilities, including the use of standardized and non-standardized methods. The actual evaluation criteria that are used to determine the success of the program are determined by the type of instrument. For example, if a standardized reading test, such as the Wide Range Achievement Test, was used, the criterion may be that a child must improve one grade equivalent.

If frequency data were used to assess how often a child threw a ball to a friend on command, the criterion for success might be that the child throw it 9 times out of 10, whereas, previously the child would only hold the ball.

If duration data were used to assess how long

a child maintained eye contact with a teacher, the criterion may be 10 seconds, where before the child did not have any eye contact whatsoever.

The amount of success expected is determined before the program, taking into account the child's learning rate. Clearly, using an IQ test or reading test may not be appropriate for some very handicapped individuals so that highly specific behaviors assessed by frequency, rate or duration measures would be more appropriate.

N. Evaluation Procedures

Just as it is important to do the assessment of a child using frequency for the length of time which then is a rate, it is important to do it at the same time on the different days. If the data are collected at different times, such as before lunch and after lunch on different days, this can lead to extraneous factors influencing the performance.

Similarly, the same person should collect the data on the different days or, if someone else does, reliability must be established. That is, the two observers must observe together to determine whether or not they agree on what the child is doing and how often s/he does it. Reliability of observation is one of the most important requirements that must be fulfilled before an IEP can be seen as having been completed. Just as standardized instruments for assessment must fulfill the requirements of reliability and validity, so, too, must non-standardized methods.

In developing and assessing IEP's, both parents and teachers must agree that the child has completed the task so that there must be reliability of assessment. If the teacher says that the child has completed the program in the IEP, but when the parent observes the child and does not agree that the child has, in fact, completed the program, reliability is zero.

Reliability using frequency is calculated by dividing the number of times that a behavior is seen by one person by the number of times that it is seen by a second person. As an example, if one teacher sees a child interact nine times with another child and another teacher sees the child do it six times, the reliability of observation = 6/9 or .66. Generally speaking, reliability should be about .80 or better to be acceptable.

Individual Program Plans (IPP)

Client's Name/Signature:_____ Date of Meeting:_____ Date Started:_____

Program Area:_____ Those Attending:_____ Date Completed:_____

Parent's (Guardian,Advocate) Teacher/Trainer:_____
Signature/Date:_____

Objective	Teaching Strategies	
I.P.O.		Materials
		Evaluation Criteria
		Evaluation Procedures
		Baseline

SUMMARY TABLE OF EVALUATION CRITERIA AND PROCEDURES

Categories of Client Evaluation Instruments	Examples of Instruments	Data Obtained	Possible Administering Procedures
Standardized	Wechsler Intelligence Scale for children - Revised (WISC-R)	Verbal, Performance and Full Scale IQ	Pre-Post Intervention
	Wide Range Achievement Test (WRAT)	Grade equivalency scores in Reading, Spelling, Arithmetic	Pre-Post Intervention
	Vineland Social Maturity Scale (parent as respondent)	Social Adaptation and Social Quotient Sub-scales	Pre-Post Intervention
Nonstandardized	Progress Assessment Chart (PAC)	Behavior is present or not present	Pre-Post Intervention
	Teacher-made Observation Scale	Frequency, rate or duration	Pre-Post Intervention Continuous Time Sampling
	Teacher-made Test	Number correct on task measured	Pre-Post Intervention

Reliability using duration is done the same way as it is done for frequency and rate data by dividing one observer's data by that of the other observer. For example, if one observer saw that eye contact was for 40 seconds and the other, 50 seconds, reliability between these two observers would be 40/50 = .80.

Reliability of data collection should be done periodically to determine that the observers are still observing the same thing. Where a teacher is assessing the child's performance, s/he could have someone assess with her or him to establish reliability.

There are several evaluation procedures including pre- and post evaluation, continuous or time sampling.

1. Pre- and Post Evaluation

Most often evaluation of the client is done before whatever intervention or teaching is to be done and afterwards. This evaluation procedure is usually termed pre- and post-assessment. Since the reason for evaluation should be to assess strengths and weaknesses and should lead to an intervention plan, the "pre" evaluation is a baseline measure. If a standardized evaluation tool, such as the WISC-R, is used, little can be derived from the client's performance on the WISC-R for help in setting up a training program. If such is the case, then a non-standardized tool also may need to be used. In addition, it is difficult to determine just how well a client is progressing towards the criterion for success using a standardized tool. With a non-standardized tool,

it is relatively easy to observe to see how close the client is to actually meeting the goal.

2. Continuous Evaluation

A second evaluation procedure is to do continuous monitoring of the client, which means that as the client does each task, the teacher or observer records that it has been done well or not. Continuous monitoring is time-consuming for the observer but is useful in ascertaining exactly where the client is having difficulty and then making changes in the intervention so that the client can succeed.

If a young man is working at shape discrimination in a vocational training situation and he does well on shapes with 3 or 4 sides but has difficulty on shapes with 5 or 6 sides, continuous monitoring of his performance would catch this. The difficulty could be analyzed and more practice given with easier blocks so that he would not be frustrated in a failure situation.

3. Time or Task Sampling

A third evaluation procedure is suitable to tasks over time, whereby, a client is observed for a random period of time and an assessment made of how well the client is performing during that time. For example, if a child's objective is to initiate contact with other children on the playground and such initiation is defined as calling a child by name, throwing a ball to a child or touching a child's arm, rather than ob-

serve the child for the entire time s/he is on the playground, the teacher may observe for 5 minutes. The number of times that the child initiates contact during those 5 minutes is then considered indicative of his/her success. Generally, several time-samples are required at different times so as to get a stable estimate of the child's behavior.

Task sampling is similar to time sampling, but describes the situation where the teacher takes a section of a child's work to see the level of success.

O. Baseline

The last aspect of the present IPP/IEP format is the baseline. The baseline refers to the level at which the client performs the task to which the IEP/IPP refers before intervention or training. For example, a boy may only be able to say the sound "b", but his IEP is to have him say the word "ball." His voice may be audiotaped for comparison purposes later.

When obtaining a baseline, whether using a standardized or a non-standardized instrument, it is important to get a stable estimate of the client's performance. Just observing the client may cause a change in his or her behavior or s/he may have had difficulty getting to school or s/he may have been yelled at, each of which may influence how well they perform.

V. Developing an IEP/IPP

A. Defining Objectives

In order to ensure that the IEP/IPP meets the criteria of being individual, specific, observable, replicable and measurable, each must be defined carefully. Usually, such defining is said to be in behavioral terms. Each object should be related to an ongoing curriculum or treatment program with sequences of steps so that once one objective has been met, the next in the sequence (usually developmental) can be started. That is, as the child learns how to follow single, simple commands, s/he then may go onto several commands, the single complex commands and, finally, several complex commands. Or as the child learns to discriminate three-dimensional objects of several sizes and complexity, s/he may go on to discriminating two-dimensional objects and on to letters.

It is difficult sometimes to be as specific as needed in defining an objective; however, there are several steps involved.

The following table demonstrates the process involved.

LEVELS OF SPECIFICITY

I	II	III
- to dress	- to put on pants	- to put one leg in - to put the other leg in - to pull pants up - to button - to zipper
	- to put on shirt	- to put one arm in - to put other arm in - to button (zipper)
	- to put on shoes	- to put shoe on - to put other shoe on - to tie laces

In the above example, the objective for one boy may be "to dress by himself on time" and it would be realistic to expect that he could achieve this in a short time. For another boy, the objective may be "to put on his pants" and he would be expected to achieve this in a short time.

Another example of defining an objective is "cleaning up after dinner."

LEVELS OF SPECIFICITY

I	II	III
- cleaning up after dinner	- cleaning table	- removing dishes - throwing scraps away - putting dishes in sink - filling sink with water - removing tablecloth - shaking tablecloth
	- washing dishes	- adding soap to water - washing each piece - rinsing each piece - placing each piece on mat
	- putting dishes away	- drying glassware - drying dishes - drying silverware - putting silverware in appropriate compartments - putting glassware away - putting dishes away

For one child, again, the objective may be "cleaning up after dinner"; however, for another, each component may be an objective.

B. Sample IEP/IPP

The following IEP/IPP's were selected as samples to help others in developing their own.

Child's Name: Jay (I.P.O) Date Started:

Curriculum Area: Social Behavior Date Completed:

Objective	Teaching Strategies	Materials
I.P.O. I. Will be able to attend to a task for fifteen minutes in the center or school II. Will generalize to home and later to school	Will be run simultaneously with "letter recognition" program. If Jay will sit through task, will receive verbal praise. If he cannot, T will ask him to look at letters and continue. If Jay leaves seat, T give instruction to sit and if not obeyed, T ignores Jay for one minute. If Jay sits, then he is praised. If he does not sit, he is taken by the shoulders and seated and program is continued. Program will be transferred to home and school.	Same as letter recognition Criteria: Fifteen minutes at desk without getting up from chair. Baseline: Sits for up to two minutes at any one time depending on task.

INDIVIDUAL PROGRAM OBJECTIVES

(I.P.O)

Child's Name: Jay

Curriculum Area: Social Behavior

Date Started:

Date Completed:

Trainer:

Objective	Teaching Strategies	Materials
I.P.O. I. Will be able to work on task in school for fifteen minute periods, breathing properly II. Generalize to home and school III. Increasing length of time	will be instructed not to hyperventilate and for each 30 seconds without hyperventilation, will receive star. Each day number of stars for picture to take home will vary so that he will get one each day. Will take car home with stars for his father and his teacher. If he hyperventilates, it will be ignored. As he succeeds, time will be increased. Program will work at first only fifteen minutes set aside for reading for fun so as to not jeopardize letter recognition task.	kitchen timer coloring book reading primer Criteria: breathing without hyperventilation for 15 m

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Baseline:
In presence of mother, Jay hyperventilates times each minute. In presence of mother a therapist hyperventilates only when she spe to him. In presence of teacher or therapis hyperventilates once every 2 minutes.

Form F/7r

Child's Name: Jay (I.P.O)

Curriculum Area: Letter recognition

Date Started: _____

Date Completed: _____

Trainer: _____

Objective	Teaching Strategies	Materials
I.P.O. I. Will recognize all of the letters in the alphabet when asked to point to them. a. three dimensional upper case letters b. three dimensional lower case letters II. Will be able to say name of all letters when pointed to for both upper and lower case (three dimensional). III. Will be able to recognize and name both upper and lower case letters printed on standard lined paper. IV. Will do this for parent as well.	T(trainer): point to--(will use all upper case first). If Jay points correctly, will receive check mark and verbal "good": Five checks = 1 small star and piece of potatoe chip. Five small stars = 1 large star and 1 picture in coloring book. Every 15 minutes, Jay can eat his chips and color 1 page or for 5 minutes. If Jay is incorrect, T says "No; this is _____: Point to_____ Jay will start with groups of 5 letters. Will receive 2 trials per condition for each session.	Three dimensional block letters about 1 inch high. Different sized stars. Coloring book. Criteria: 80 per cent accuracy when all letters (upper or lower case) are presented in unsystematic order and/or are placed in front of him all at one time. Baseline: Was able to recognize and point to A,B, and C (and a,b and c) all of the time, but guessed at other letters.

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Form 7/78

INDIVIDUAL PROGRAM OBJECTIVES

(I.P.O)

Child's Name: Alan

Curriculum Area: Social Behavior

Date Started:

Date Completed:

Teacher:

Objective	Teaching Strategies	Materials
I.P.O. I. Will behave properly in school A. Will follow commands 1. look at me 2. come here 3. give me_____ 4. sit down 5. pick up_____ B. Will sit at desk for progressively longer lengths of time C. Will be able to perform simple perceptual tasks 1. string beads from model 2. put 5 piece puzzle together 3. sort red & yellow blocks by color 4. match colored pieces of paper by shape (square, circle, triangle) II. Will behave at home and in school	T (teacher) alone with C (child) at first. T will give C command, "look at me". If C does, T will praise him and give piece of chip. If C does not, T will repeat command. If C tantrums, T will say "no!, stop yelling" and turn away until he has ceased for 30 seconds. T will praise him for being quiet and repeat command. Commands and tasks varied as process repeated. If C succeeds, mother will come in as reinforcer and then to work on tasks. Generalization to home and school.	Three dimensional blocks, red and yellow; potatoe chips; colored paper; wooden puzzles of elephant, clown and house. Criteria: Time at task will increase to 5 minutes without crying. Will respond to commands 4 of 5 times Baseline: Tantrumed incessantly, unable to do any tasks.

Form E/7c

INDIVIDUAL PROGRAM OBJECTIVES

(I.P.O)

ild's Name: Nicky

rriculum Area: Academics

Date Started: _____

Date Completed: _____

Teacher: Parent

Objective	Teaching Strategies	Materials
P.O. I. Will recognize animal pictures including hope, cow, pig, dog, cat, duck and bird. a. receptively, that is, will be able to point to the correct animal from an array of 2,3, or 4 pictures when asked. b. expressively, that is, will name picture when pointed to by the teacher. II. Will hold crayon and trace geometric designs including circle square and triangle all about one inch. II. Will copy designs.	I. The parent will start with two pictures having him pick out one, then the other with random changing. If he does not do it, parent will label each picture and repeat. If he cannot discriminate between 2, parent will go to 1 at a time. He will name each. II. Parent will demonstrate how to hold crayon, will hold his hand and follow lines gradually removing the control	Colored pictures of animals. Orange juice and straws. 3" x 5" unlined cards. Criteria: 100 per cent recognition and expression. Designs to be recognizable. Baseline: Would not say any animal name or point to any animal. Refused to hold crayon even if crayon held in his hand by teacher. Figures are completely distorted.

4.83

INDIVIDUAL PROGRAM OBJECTIVES

(I.P.O)

ild's Name: Nicky

rriculum Area: Socialization

Date Started:

Date Completed:

Teacher: Parent

Objective	Teaching Strategies	Materials
P.O. I. Will attend to task for 15 minutes. II. Will follow sample commands III. Will maintain eye contact with parent	I. will be run simultaneously with academic tasks. Parent will reinforce him periodically as he seminars seated. Will change tasks and play patty-cake or sing as a break. If he does not attend, parent will direct his attention by telling him to look. If he begins tantruming or walks away; parent will turn away from him until he has been quiet for 30 seconds or returns to seat. Parent will do these at home nighly for 30 minutes.	Criteria: Will look at parent on command. Will remain at seat for progressively longer periods to 10 minutes.

Baseline:

Would not separate from parent; clings to paren screams when he is forced.

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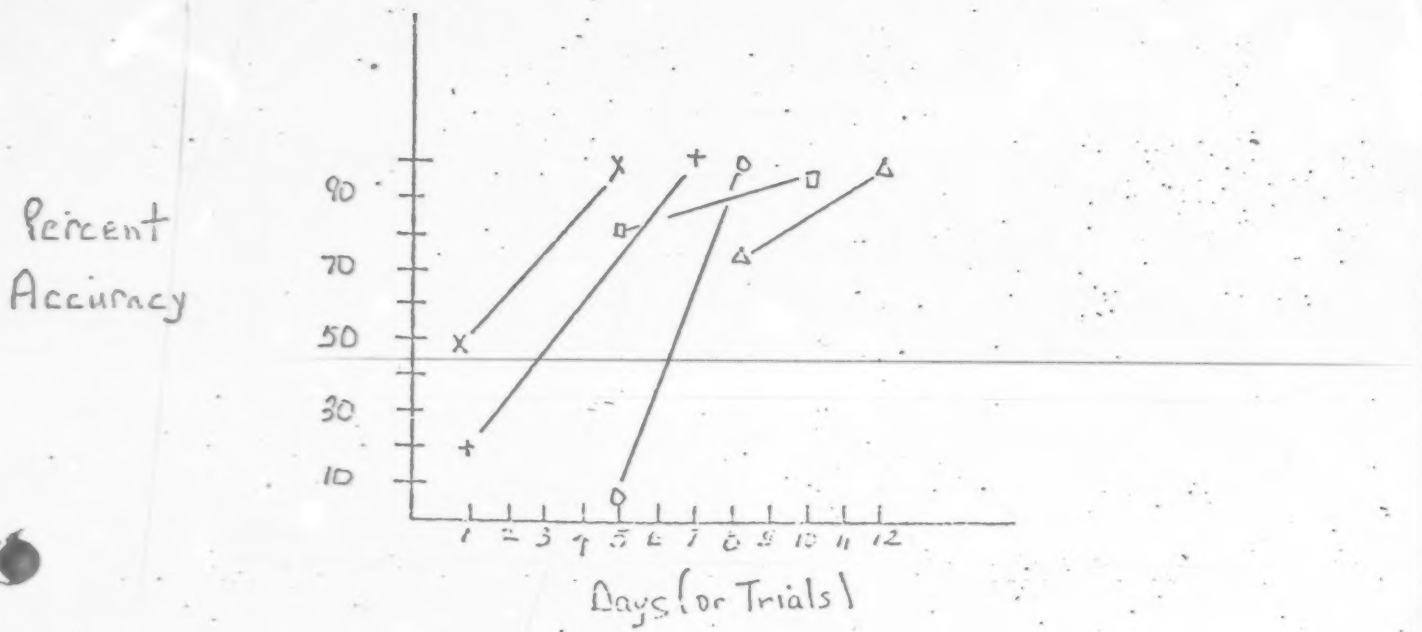
rm E/7c

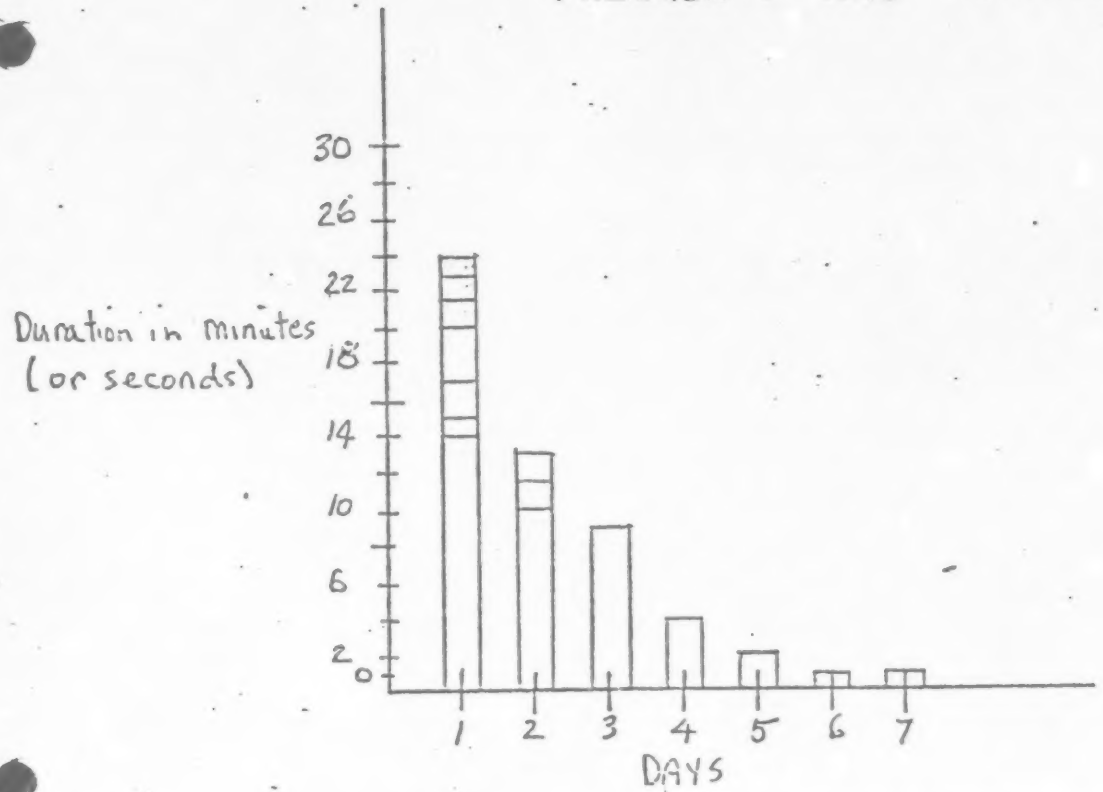
CONTINUOUS DATA

PRE / POST DATA



SAMPLE WAY TO PRESENT DATA GRAPHICALLY

CUMULATIVE TIMEOUT DATA SHOWING FREQUENCY AND DURATION



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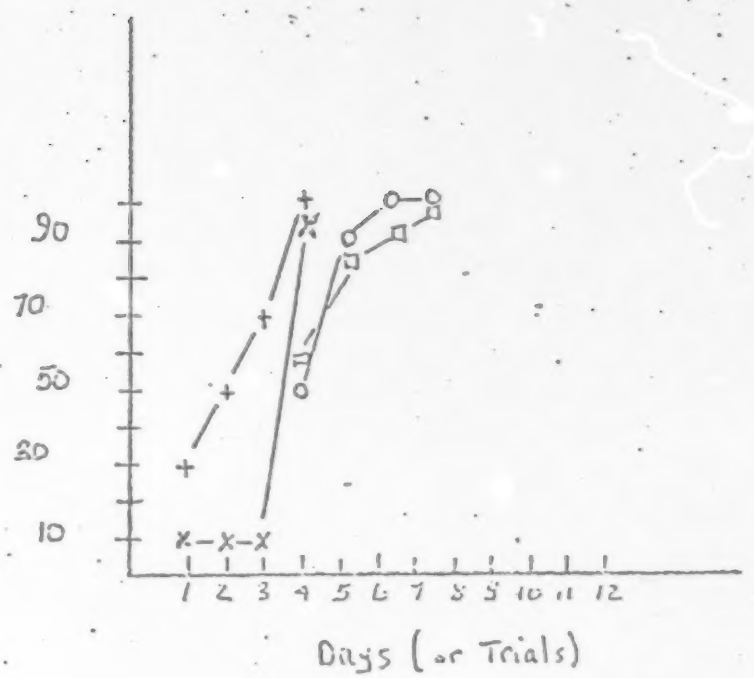
1	2	9:14	9:15	1'
1	3	9:27	9:29	2'
1	4	10:03	10:06	3'
1	5	10:3	10:36:30	1'30"
1	6	11:00	11:01	1'
1	7	11:01	11:02	1'
2	1	9:00	9:10	10'
2	2	9:59	10:00:30	1:30"
2	3	11:59	12:00	1'
3	1	9:00	9:09	9'
4	1	9:00	9:04	4'
5	1	11:58	12:00	2'
6	0	—	—	—
7	0	—	—	—

COGNITIVE

CONTINUOUS DATA



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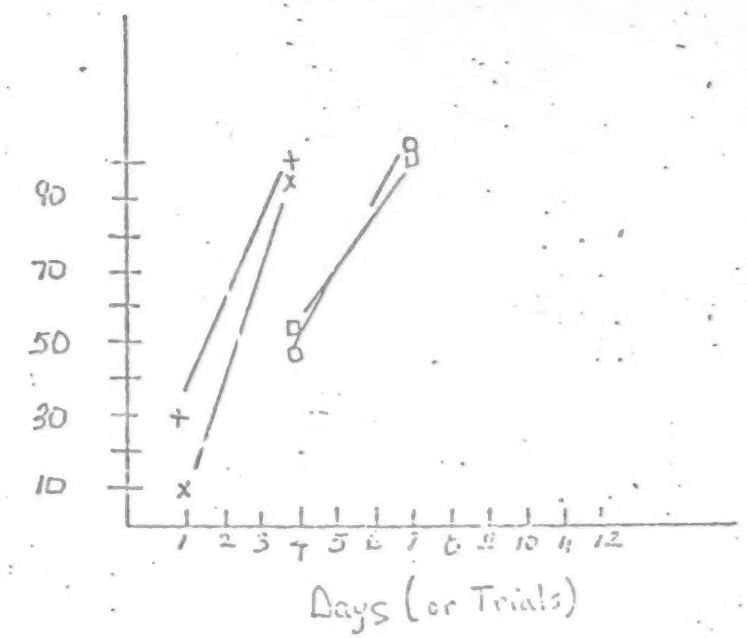
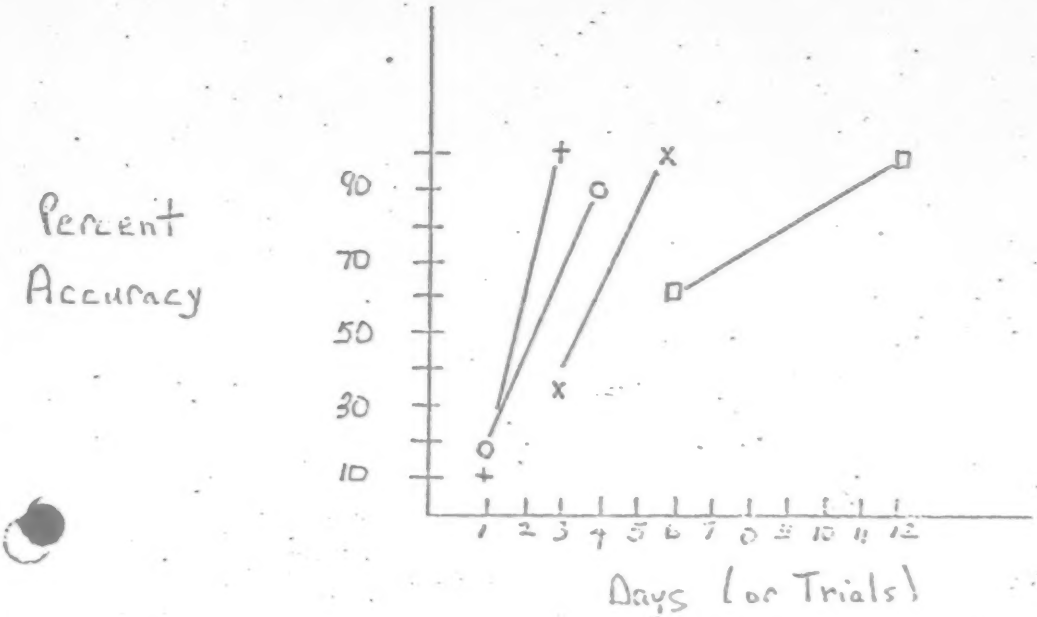


SAMPLE GRAPH

LANGUAGE

CONTINUOUS DATA

PRE / POST DATA



SAMPLE GRAPH

SAMPLE SCORING RECORD

ctivity e.g., clean room)	Times Done 1 2 3 4 5 6 7 8 9 10	ard

Code:

+ = correct
0 = incorrect
- = approximation
θ = approximation & prompt
/ = no response